PUBLIC HEALTH NURSING

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OUR NATIONAL EMBLEM

Some of the new members of the National Organization for Public Health Nursing have been eager to learn the history and meaning of our seal, and in response to this desire we are reproducing it in this issue, and giving its early history.

Quoting a paragraph from the *American Journal of Nursing* of April, 1909—

"At the conference of visiting nurses in Chicago, in April, last year, the adoption of a common seal or emblem for all visiting nurse organizations was discussed. The Cleveland organization submitted several designs at that time, one of which seemed to embody the real purpose and future of the work, and after giving every society opportunity through the *American Journal of Nursing* of offering suggestions and designs it has finally been decided by common consent of several larger organizations to adopt a common emblem giving every organization a right to use it, by paying the cost of the die. The design decided upon is the one submitted by the Cleveland association."

At the National Convention of the American Nurses' Association, in June, 1912, at which time the National Organization for Public Health Nursing was founded, Miss Matilda L. Johnson, delegate from the Visiting Nurse Association of Cleveland, read the following communication:

"The Visiting Nurse Association of Cleveland, through the generosity of two of its trustees, Mrs. E. S. Burke, Jr., and Mrs. Robert L. Ireland, is able to offer as a gift to the National Association a seal designed by the sculptor, Herman Matzen, of Cleveland. It portrays the following idea:

"The tree of life represented by a young tree in the hand of a kneeling woman and bearing this legend: 'And when the desire cometh it shall be a tree of life,' indicates that the great work to which visiting nurses are dedicated is the implanting in the hearts and minds of the sick poor the desire for better, cleaner, higher living that will enable them to work toward their own rescue from the unfortunate conditions which hold them back from happier things.

"The adoption of this seal as a national emblem and as an insignia to denote a standard of visiting nursing was one of Mrs. Robb's dearest wishes. We cannot help feeling glad that we now have an opportunity of offering the seal to one national association, rather than to many associations doing visiting nurse work. Great work calls for a great standard and the standard calls for the protection of a national organization."

The beautiful significance of the seal was expressed in an editorial in *The Visiting Nurse Quarterly,** a number of years ago, in words so adequate that we quote them once more:

"We have before us a symbolical tree of hope and desire—frail and young, it is true, but being tenderly and firmly planted, with high courage and the belief that it will find such strength and nurture in the soil as to enable it to become broad-spreading and a tree of refreshment for many.

"One can fancy, too, that there stirs about this picture a spirit of coming generations who, resting a little from their labors under the full leafage of this pleasant shade may perhaps think with sweet remembrance on those who in an earlier day planted and tended the little tree with a belief in its power to grow.

"We feel that the design symbolizes a larger hope, a more continuous and beneficent influence on the part of the nurse in the home than if she were portrayed simply in some act of material ministration. She comforts the sick body it is true, and far is it from our thought to minimize the high quality of this service, but with her entrance into the home there goes also with her something better even than she consciously knows—the transmission of hope, of courage, the promise of something better, something that comforts the whole being and sustains all effort toward good in the disorganized home and among its members."

Those words were written before the foundation of our National Organization, and the pin now worn by members of the Organization bears the same design that, in those earlier days, became the visible evidence of the unity and standard of visiting nursing which sought and found its fuller embodiment in the National Organization for Public Health Nursing.**

* Now PUBLIC HEALTH NURSING.

** This description appeared in part in the June (1921) number of THE PUBLIC HEALTH NURSE.

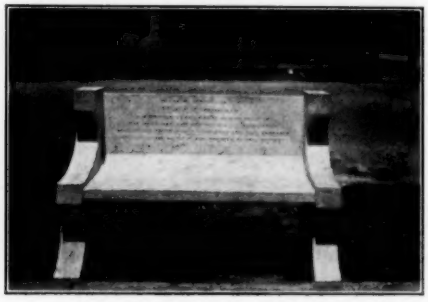
Information as to the N.O.P.H.N. pin may be found on page 31 of the Advertising Section.

MEMORIALS TO NURSES

Savannah, Georgia, and Hinsdale, Illinois, have honored the memory of two public health nurses who died in active service.

To Eva Cunningham, for fifteen years a member of the staff of the Mary Maclean Visiting Nurses Association (now the Savannah Health Center) the members of the Association and the East Side Mothers' Club and Kindergarten have erected and dedicated a marble bench in her old district. A part of the inscription on the bench reads: ". . . by her faithfulness, sympathy and skill [she] endeared herself to the mothers and children of this district."

To the memory of Elsa Singdahlsen, who served long and faithfully as community nurse in Hinsdale, the village has planted a large evergreen tree which stands in the public park. The tree will be lighted each Christmas in her memory.



Toxoid the Next Step in the Conquest of Diphtheria

By MILLARD KNOWLTON, M.D.
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FEW of us realize what diphtheria meant to a community before mankind acquired knowledge leading to its control. The writer once found a small volume in the Boston Public Library which gives a vivid description of an outbreak of angina, apparently diphtheria, that visited a town in Massachusetts Colony about two hundred years ago. During the outbreak most of the usual activities of the community were suspended and when it was over the town cemetery contained mounds of earth covering the remains of one or more children from almost every family in the town. While diphtheria is primarily a disease of childhood, it may also affect adults who have escaped the immunizing process earlier in life. It is said that Washington died of diphtheria.

A Very Ancient Disease. Students of history find reference to diphtheria in all known countries dating from ancient times. It was referred to in the Babylonian Talmud. An accurate clinical description appeared in the first century A.D. Paralysis of the palate was recognized in the sixth century A.D. Throat pestilences are mentioned in the Middle Ages. Severe epidemics occurred in Europe during the sixteenth and seventeenth centuries. The disease continued to appear in epidemic form throughout the known world until very recent times. In our large American cities such as Boston, New York and Chicago, severe epidemics of diphtheria occurred at intervals of from five to ten years until less than forty years ago.

EPIDEMIC DAYS ARE OVER

But these epidemics no longer occur. Within recent years such severe epidemic outbreaks of diphtheria have not taken place. The occurrence of severe epidemics of diphtheria ceased at about the time the use of diphtheria antitoxin became common. More recently the prevalence of the disease has been greatly reduced by further advances in its conquest. Within the past ten years, some communities have almost eradicated this scourge of childhood by the consistent and persistent application of known preventive measures.

Many Steps in Conquest. The fight against diphtheria is more than a "thirty-years' war." The struggle has been going on for a much longer period and the end is not yet. The first step in the real conquest of the disease was the discovery of the diphtheria bacillus by Loeffler in 1884. The next great step was the development of diphtheria antitoxin by Von Behring a few years later. Knowledge of the bacillus permitted cultures for diagnosis and the recognition of carriers. When the merits of diphtheria antitoxin became recognized, it was used extensively as a means of curing cases of the disease. The use of antitoxin is also of great importance in preventing diphtheria. Its preventive influence is exerted in two directions. In the first place, the prompt cure of cases by antitoxin shortens the time during which patients are highly infective and thus lessens the hazard to their associates. In the second place, a prophylactic dose of antitoxin gives temporary protection and thus limits the number of cases among persons in contact with patients. The discovery and isolation of carriers also helps in preventing the spread of disease.

PREVENTION BY IMMUNIZATION

While prompt treatment of cases and temporary immunization of contacts by antitoxin, and the control of carriers

by discovery and quarantine, have so limited the spread of diphtheria as to prevent the occurrence of severe and devastating epidemics, these measures did not go far enough. The disease was still entirely too prevalent and many neglected cases were fatal. Something had to be found to afford permanent protection instead of the temporary protection provided by antitoxin. It was perceived that this could be accomplished only if each individual could provide his own protection by developing his own immunity. Each person must rely upon his own acquired protection—not lean upon the horse for antitoxin during an emergency. It is known that most persons become immune to diphtheria without an attack of the disease merely by becoming carriers of the diphtheria bacillus. Careful search was made for a way to induce this immunity at will and a way was found.

Toxin-antitoxin Prevents Diphtheria. Immunity against diphtheria is an antitoxin immunity. A child will not develop diphtheria, even though a carrier of the disease organism, if his blood contains one unit of antitoxin per ounce. It appears that only the presence of diphtheria toxin will induce the body to manufacture its own antitoxin and keep a constant supply circulating in the blood. A mixture of antitoxin and toxin makes a preparation which can be administered in a limited number of doses and which will cause immunity to develop in the majority of cases. That this is true is evidenced by the notable drop in diphtheria incidence and deaths in many cities and communities following the inauguration of immunization campaigns.

IMPROVEMENTS IN PROCEDURE

With many research workers studying all phases of the diphtheria problem, the early immunizing procedures have been improved. For example, the reactions from toxin-antitoxin in a small number of children when the material first came into use have been brought under control by adjustment of the dose. The culture filtrate from which toxin-antitoxin is made contains certain bacterial proteins in addition to the diphtheria toxin. A few older children and adults are sensitized to these proteins so that the use of toxin-antitoxin in the dose formerly employed, 3 L+ doses of toxin to the dose of toxin-antitoxin, gave rise to reactions in a certain number of cases. Such reactions varied from slight redness to disagreeable swelling at the point of injection, malaise, headache and fever. Experimentation showed that a much smaller amount of the toxin, when combined with an appropriate amount of antitoxin, would have almost as high immunizing value with very little likelihood of disagreeable reaction. Thus it was found possible to cut the amount of toxin from 3 L+ doses to one-tenth L+ dose, or one-thirtieth the amount formerly used, and still have satisfactory immunizing effects almost without reaction.

Horse Serum Toxin-antitoxin. For various reasons the horse is almost universally used in the preparation of antitoxin. Thus it was natural for antitoxin obtained from horse serum to be used in the preparation of toxin-antitoxin. Although refined and concentrated antitoxin is used for this purpose, it may still contain a very minute amount of horse serum protein. Some physicians have felt that the use of toxin-antitoxin made from horse serum antitoxin may sensitize patients to horse serum and thus result in serum sickness in case the administration of tetanus antitoxin, scarlet fever antitoxin or other horse serum preparation should become necessary in the future. Other physicians have doubted the sensitizing effect of such toxin-antitoxin and have pointed out that the evidence submitted is not conclusive. The fact that a number of physicians suspect that horse serum toxin-antitoxin may sensitize patients to horse serum, would appear to justify finding a substitute for this preparation no matter what may be the merit of the contention.

A Substitute for Horse Serum. To meet the demand of physicians who ob-

jected to horse serum toxin-antitoxin, manufacturers began making the preparation with antitoxin derived from sheep serum or goat serum. Since other antitoxins are made from horse serum, sensitization to sheep serum or goat serum would do no harm. In recent years the trend observed in many parts of the country toward the use of toxin-antitoxin made from goat serum or sheep serum instead of the horse serum product has represented an attempt to meet the demands of physicians. In fact the trend has become so marked that some manufacturing laboratories have ceased using antitoxin from horse serum in the preparation of toxin-antitoxin and use only antitoxin from sheep serum or goat serum. Some difficulties both in the process of manufacture and in the results of administration have been encountered as a result of this change.

Relative Advantages. In the first place the horse appears to be a more suitable animal for producing diphtheria antitoxin. It is said that from 1,000 to 1,200 units of antitoxin per cubic centimeter of blood from a well-immunized horse may be reasonably expected, while as much as 150 to 200 units per cubic centimeter from the blood of an immunized goat is considered a high yield. Furthermore, goat serum toxin-antitoxin appears to be less stable than the horse serum product so that the goat serum combination may break up and become toxic on slighter provocation. It is desirable to have some free toxin in the mixture in order to stimulate the production of immunity. However, too great an excess of free toxin may cause undesirable reaction. In a few instances that have been investigated undesirable reactions from goat serum toxin-antitoxin appear to have followed the long exposure of the mixture to low temperatures prior to its use. In the dose now used horse serum toxin-antitoxin does not cause such reactions after exposure to similar temperatures. Although the reactions observed from the use of goat serum toxin-antitoxin have been unpleasant rather than dangerous, it seems desirable to avoid all reactions that might cause hesitation on the part of parents in having children immunized against diphtheria.

Immunizing Power of Toxin-antitoxin. Within the past few years a number of health officials have become disturbed upon finding that a smaller percentage of children were negative to Schick tests after toxin-antitoxin than they had expected. The work of Park in New York would appear to justify an expectation that about 85 to 90 per cent of children would become Schick negative after receiving toxin-antitoxin. In some sections of the country the percentage has fallen below this point. In other sections groups of children given the Schick test after toxin-antitoxin have shown a Schick negative percentage which compares favorably with that obtained in New York. Since all lots of toxin-antitoxin must come up to standards fixed by the United States Public Health Service before being placed on the market, the question arises whether or not the preparation may lose some of its immunizing power under certain conditions of handling. Whatever may be the explanation, it is apparent from data now available that there is still room for improvement even in so valuable an agent as toxin-antitoxin. This improvement has come and has opened the way for still further progress in our conquest of diphtheria.

DIPHTHERIA TOXOID THE NEXT STEP

For the preparation of the toxin-antitoxin mixture, diphtheria toxin is obtained by growing diphtheria bacilli in a broth culture and then filtering out the germs. The toxin produced by the germs during the process of growth remains in the filtrate and is almost neutralized by the addition of antitoxin in preparing the toxin-antitoxin mixture. Ramon discovered a method of detoxifying the toxin in the broth culture filtrate without the use of antitoxin. Instead of almost neutralizing the toxin in the filtrate by the addition of antitoxin, Ramon adds a small

amount of formaldehyd and places the material in an incubator. The formaldehyd acts upon the toxin in such a way that it becomes entirely non-toxic but retains its immunizing power when given to children. The product of this procedure is called "diphtheria toxoid." It is also called "anatoxin Ramon," but the word, "toxoid," is less apt to be confused with "antitoxin." Diphtheria toxoid is now rapidly coming into use as a substitute for the toxin-antitoxin mixture.

Toxoid in Canada. In the United States the use of toxin-antitoxin had become rather firmly established before the advantages of diphtheria toxoid were recognized. In Canada the use of diphtheria toxoid as a substitute for toxin-antitoxin was begun in 1925. After the exclusive use of diphtheria toxoid since that time, health officials in Canada report that they are well satisfied with the preparation and that they would not go back to the use of diphtheria toxin-antitoxin.

More Toxoid in the United States. In this country the use of diphtheria toxoid is rapidly becoming more extensive as its virtues are more generally recognized. On June 20, 1930, Dr. W. T. Harrison of the United States Public Health Service, read a paper before the Annual Conference of State and Provincial Health Authorities of North America, on "The Relative Immunizing Value of Diphtheria Toxin-antitoxin Mixture and Diphtheria Toxoid." Harrison reported that of 475 school children given diphtheria toxoid, 95 per cent had developed an immunity response as measured by the Schick test, as compared with 64 per cent of 355 children given the toxin-antitoxin mixture. These figures show a striking difference in favor of toxoid. As already stated, a few workers in other parts of the country have reported rather disappointingly low percentages of children showing immunization after toxin-antitoxin, and Harrison's figures add further evidence to indicate that under certain conditions toxin-antitoxin may not come up to expectations as an immunizing agent. In view of these considerations it is not surprising that diphtheria toxoid should be more extensively used by both private physicians and health officials.

ADVANTAGES OF TOXOID

Diphtheria toxoid has several advantages over toxin-antitoxin. Some of the important ones may be listed as follows:

1. Toxoid does not contain animal serum and for that reason does not sensitize to animal protein.
2. Immunity develops more rapidly after toxoid than after toxin-antitoxin.
3. A higher percentage of children become Schick negative after two doses of toxoid a month apart than after three doses of toxin-antitoxin a week apart.
4. The use of two doses instead of three simplifies the procedure.
5. The simplified procedure will make it easier for the family physician to immunize young children.
6. Toxoid is a more stable product than toxin-antitoxin and is much less likely to deteriorate upon standing.
7. The cost of manufacture is less for toxoid than for toxin-antitoxin. This is of particular interest to board of health laboratories that manufacture their own products.

A Good Case for Toxoid. These advantages appear to make a fairly good case in favor of diphtheria toxoid and the favorable impression is confirmed by experience. Those who have used toxoid are its most enthusiastic advocates.

The Disadvantage Easily Overcome. Practically the only disadvantage of toxoid as compared with toxin-antitoxin in the dose now used is the occasional occurrence of reactions in older children and adults. Overcoming this disadvantage simply consists in procedures that will avoid an undesirable reaction. The best way to meet this situation is to immunize all children before they are old enough for such reaction to occur. It is recommended and urged that this be done by the family physician as a routine. In immunizing older children special procedures may be followed to avoid reaction.

Reaction Age. The few older chil-

dren who react unduly to diphtheria toxoid do so because they have become sensitized to proteins resulting from growth of the diphtheria bacillus. The age at which children may become so sensitized varies with opportunities for exposure to the diphtheria bacillus. In rural communities that have been free from diphtheria for a number of years very few children of grammar school age are likely to be sensitized to the diphtheria bacillus protein. In cities where diphtheria has been recently prevalent the number of sensitized children is apt to be higher. To meet the need for fixing a standard age limit for possible sensitization, we in Connecticut have advised that all children below seven years of age be given the toxoid without further tests, and that additional procedures be carried out in the case of older children to avoid reaction.

Bacterial Proteins Cause Reaction. Sensitization to bacterial proteins present in the broth culture filtrate is evidence of previous exposure to the diphtheria bacillus. The power of such proteins to cause reaction in sensitized persons is not removed by the formaldehyd in the preparation of toxoid. The usual dose of toxoid contains much more of the original broth culture filtrate than does the usual dose of toxin-antitoxin. This may explain in a measure why toxoid is a better immunizing agent than is toxin-antitoxin, and also why it is more apt to cause reaction in susceptible persons. Such reactions vary in intensity from a slight reaction of no consequence to a severe reaction with induration and redness extending around the site of injection together with malaise, headache and fever. These symptoms disappear in two or three days. They are unpleasant rather than dangerous, but it is desirable to avoid them.

Use Full Strength Toxoid. It is said that some manufacturers dilute toxoid to about one-fourth its original strength in order to lessen the likelihood of reactions resulting from its use. Such dilution will also limit its immunizing power. It is believed advisable to use full-strength toxoid and to apply certain simple tests to ascertain what procedure to follow with older children who may be sensitized to bacterial proteins.

Reaction Tests. It is possible by special tests to ascertain what children require special immunizing technique. The "reaction test" may be made by intradermal injection of diluted toxoid using the same technique as in the Schick test. Young children may be given full-strength diphtheria toxoid without making the reaction test. It is well to give this test to older children and adults. Many reactors are immune to diphtheria and for that reason do not need toxoid. The Schick test can be used to determine who are immune. The Schick test may be given with the reaction test as a control, or the Schick test may be given only to those who react to the reaction test. Either procedure will serve the purpose of avoiding unnecessary reactions.

Toxoid for Immunizing Reactors. While it is possible to immunize reactors with the usual doses of toxin-antitoxin, it is believed preferable to immunize them with smaller doses of toxoid. At present there appears to be a definite trend toward the use of toxoid in this country. In Canada where toxoid is used exclusively it has been found practicable to immunize reactors with a larger number of smaller doses, the exact dosage to be judged by the physician on the basis of the degree of sensitization as shown by the reaction. As a matter of fact persons sensitized to the diphtheria bacillus protein are apt to give an immunity response to either toxoid or toxin-antitoxin rather more readily than persons not so sensitized.

SCHEDULE FOR TOXOID IMMUNIZATION

In shifting from toxin-antitoxin to toxoid for immunizing groups, it may be desirable to change the schedule of procedure. Toxin-antitoxin is usually given in a series of three doses a week apart. This permits a rather simple schedule for giving immunizing treatments the same day each week for three weeks. Some have adopted a similar schedule for toxoid. Since two

doses of toxoid a month apart give satisfactory results, the schedule may be adjusted to this procedure. The interval between doses may be lengthened to five or six weeks if desired, but it is better that it be not less than a month where only two doses are given. Where the reaction test is given to older children it is necessary to inspect them three days after the test to ascertain if the reaction calls for modified immunization procedure. Those who do not react may be given the two doses of toxoid a month apart as are the younger children. Those who do react may be given a larger number of smaller doses of toxoid grading the dose each time to the degree of reaction from the preceding dose.

Procedure Not Difficult. As a matter of fact the work of immunizing a group of older children with toxoid is not nearly as difficult as the description may make it appear. When toxin-antitoxin is given without a preliminary Schick test, each child must be seen at least three times in order to be given the three doses. Occasional reactions may call for more frequent observation. When toxoid is used, the younger children need be seen only twice while older children must be seen more frequently. The first time they will be given the reaction test. When this test is read the first dose of toxoid will be given and the second dose a month later. The very few who react to the reaction test will require a little more attention. The use of the Schick test will lessen the number to be given immunizing treatment.

Give Toxoid at Early Age. The best time to immunize children against diphtheria is as soon as practicable after they reach the age of six months. At this time, or in fact at any time up until they enter school, the use of toxoid is very simple. There is no need for a reaction test and all that is necessary is to give them two doses a month apart. It is important to immunize children early because diphtheria is more dangerous to very young children than to older ones. More than one-fourth of the cases and over half of the deaths from diphtheria reported in Connecticut during the past few years were in children under five years of age. In fact over three per cent of the cases and seven per cent of the deaths have occurred under one year of age. Immunity developed from the administration of toxoid may be expected to last many years, probably for life in most cases. Because of the special hazard of diphtheria to young children it is advisable to have as many children as possible immunized before they reach school age.

Immunization by Family Physician. The use of toxoid in two doses a month apart makes it very easy for the family physician to immunize a young child. If the mother is bringing her infant into the physician's office for regular monthly conferences, these doses can be given at the time of such visits. Having diphtheria immunization treatments given by the family physician is in accord with the trend of modern medicine toward the utilization of preventive procedures insofar as practicable. The immunization campaign carried on in connection with schools may be considered as primarily educational in character, designed particularly to furnish the public information concerning the value and purpose of diphtheria immunization. When these matters are fully understood by the public at large, it is in accord with our institutions in America for immunization procedures to be carried out by the family physician.

Tests for Immunity. The results of treatment with toxoid may be judged by giving a Schick test after the treatment. According to Harrison's experience more than 90 per cent of those treated should be Schick negative two or three months after the last injection and a still higher percentage six months after the last dose. Those found to be still Schick positive should be given another immunizing treatment.

Postgraduate Preparation for Industrial Nursing*

By KATHARINE FAVILLE

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FOR over thirty years the number of public health nurses in the United States has been steadily increasing. Begun as a means of giving nursing care to the sick poor in their homes, the rapid advances of the medical and social sciences have brought ever increasing opportunities to the public health nursing profession, and today the nurse is utilized in urban and rural districts, in homes, schools and factories, as the best means of changing the practices of daily living of the people of this country to conform to the most advanced knowledge of medical research. Employed at first by the privately supported agency—the visiting nurse association—her work soon became recognized as worthy of public support, as a good investment of public funds, and a saving of community money. Today we find public health workers all over the country trying to think in terms of community rather than of specialized group needs, with the result that the number of agencies is being reduced, work coördinated, and nurses employed to work with families as a unit under expert supervision rather than with the special problems of infancy, childhood or adult life as such. Today we look upon all public health nurses, no matter by whom employed, as belonging to this great group working for the larger purpose of community health.

THE INDUSTRIAL NURSE IS A PUBLIC HEALTH NURSE

If you ask how this concerns the industrial nurse, my answer is that professionally we no longer recognize her as a person apart from the rest of us. The ultimate objectives of all public health nurses are the same in home, school or factory, as are also the underlying principles which guide their work. Practically we vary only to that extent necessary to adapt our methods of work to the environment in which we find ourselves employed—the community nurse adapting her work to the home and clinic, the school nurse to home and school, the industrial nurse to home and plant. Moreover, none of us can give her best service without coördinating her work with that rendered by all the others in her community; so that it is only as we recognize our common purpose that we can attain our common goal.

The industrial nurse must view her work among the wage earners of the community not as something concerning only those enclosed within the four walls of the factory, but as part of that public health effort which the community is expending so that all of family life within that community may be lived at a higher level. She must know how to relate her work to that of the department of health, the schools, the private health and social agencies. As in world affairs, isolation is being made more and more impossible, so in professional spheres it is being broken through. The rest of us envy the industrial nurse her chance to gain the attention of the wage earner—all powerful in his family—who is usually absent when the community nurse visits the home. The visiting nurse, the board of health nurse, the school nurse—all will find themselves accomplishing much more effective work when once the industrial nurse sees her relation to the rest and each helps the other for the good of the family group.

This conception of every public

* Presented at the meeting of the Industrial Nursing Section, National Safety Congress, Chicago, Ill., October, 1931.

health nurse as a person who is at heart a generalist—interested in all that affects the health of each member of every family in her community—has resulted in changes in the preparation for her work. Employed in the early days, as we have said, as a nurse to give bedside care to the sick poor in their homes, the connection between what she was taught in the school of nursing and what she did in the district home was close; she cared for sick people in both instances. Then each nurse was taught by the apprenticeship method, visiting nurse associations taking students from everywhere and developing teaching programs, nurses being trained largely at community expense.

But with the great advances of preventive medicine in the last few years, with the development of our conception of health as comprising mental as well as physical well-being, there has come a widening gap between the knowledge of the care of the sick as learned in hospital wards and the knowledge necessary to teach people how to keep well. There seemed a limit, also, to the amount of money which service agencies properly could spend on the education of nurses on the job for work in communities other than their own. Gradually these educational programs have been turned over to colleges as fast as receptive institutions could be found, and today thirteen schools, well distributed over the United States, offer postgraduate courses in public health nursing which meet the standards set by the National Organization for Public Health Nursing.*

PREPARATION FOR THE JOB

Gradually, too, with increasing years of experience behind us, we have been reaching some uniformity of thought as to what constitutes the best preparation for public health nurses; and at present in most public health agencies in which policies for the employment of nurses are controlled by nurses, the following standards, approved by a joint committee of the National Organization for Public Health Nursing and the American Public Health Association, are recognized.**

First, all public health nurses should be high school graduates. In the old days this was not of such primary importance, as a high school education was not universally available. But today it is unnecessary for schools of nursing to admit students without this preparation and for nurses without it there is little professional future.

Second, a public health nurse should be graduated from a school of nursing connected with a hospital which has a daily average of at least fifty patients; for the very small hospital does not afford enough variety in clinical experience to make a good practice field for student nurses. It must be remembered that the public health nurse, no matter how much she has developed into a health teacher, is in this country still fundamentally a nurse, and should be a good one—the best obtainable. Legally she should be eligible also for registration in the state in which she works.

As yet there are not enough public health nurses with postgraduate training to fill all the staff positions available, so that health agencies employing large numbers of nurses find it economical to set up introductory teaching programs of six to eight weeks' duration for new nurses, and to continue with carefully planned programs of staff education for the older group. Such educational programs are not usually available for the nurse who works alone or on a small staff, so that for these positions the standard now set is a minimum of two years' experience on a well-supervised staff having such a program, or a postgraduate course in public health nursing. For all supervisory or administrative positions, postgraduate study is usually required.

* See PUBLIC HEALTH NURSING, January, 1932. List of approved courses available on request.

** For complete standards see THE PUBLIC HEALTH NURSE, May, 1931.

These standards are becoming so universally accepted among community health agencies that they are the common knowledge of most public health nurses. The increasing attendance at public health nursing courses attests the fact that nurses realize that to gain professional advancement, such study is necessary.

The only field of public health nursing which has not generally accepted these standards is the industrial nursing field. This does not mean that the industrial nurse has a much simpler job, and that it is unnecessary for her to know as much as the other public health nurses, for her work certainly demands all the knowledge and skill that she can muster; but it is rather to be accounted for by the fact that most industrial nurses are employed by lay people who have no knowledge of nursing educational standards, the industrial group being practically the only one where employment is not largely under the direction of the nurses themselves. If the industrial nurse group is to remedy this and to accept standards of professional fitness equal to those of the profession as a whole, special effort must be made by them in two directions:

First, each nurse must take the initiative for remedying her own educational deficiencies, for at present few industrial nurses are fortunate enough to work where modern staff education programs are provided for them, as is done for the community nurse. Moreover, she does not have the pressure exerted on her by her superiors urging her on to better preparation. Such preparation will come largely through her own interest and desire. This preparation may take the form of postgraduate study; or in large cities it might well mean getting staff education programs under way on a community rather than an agency basis, to which she will have the same access as other community workers. The present system, whereby each agency sets up its own educational program, is a costly one when we consider that it is community money which in the end is paying for it all; and there is no reason why such programs should not be coordinated and opened to the industrial nurse if she will make the effort to request access to them.

Secondly, the public health nursing profession as a whole must educate the industrial employer to an appreciation of the difference between a well trained and a poorly equipped nurse. The average layman's knowledge of nurses is confined largely to experiences with them in time of family illness, and his knowledge of nursing education standards is lacking because we have neglected as a profession to enlighten him. It is our responsibility as a group to make him see that if community agencies can no longer afford to employ the totally untrained person, surely industry can not, so long as better prepared workers are available.

WHAT DOES POSTGRADUATE STUDY OFFER?

If, however, we are to recommend postgraduate study to the industrial nurse, she must be assured that the course she is taking is worth the sacrifice entailed. What do the public health nursing courses give students which will be of value? What can she logically expect in return for the expenditure of her time and savings?

Fundamentally important from a practical point of view, the courses all attempt to make clear the rôle of the public health nurse in the field of preventive medicine and public health; which in this case means concretely the relationship and contribution of the nurse to the industrial health and safety program, the primary objective of which is prevention.

Second, the courses attempt to break down the feeling of professional isolation which develops in each of us who lives so close to the details of our work that we fail to "see the woods for the trees." If the industrial nurse is to view her work as a conscious part of the community as well as of the industrial health program, she herself must have a comprehension of the public health nursing profession as a whole,

its development and evolution, the problems which have arisen and the solutions which have seemed wise, the relationship of her professional group to that of the allied ones of medicine, social work, and education. She, as an individual, must be able to build her work on the past, profiting by group experience; not duplicating mistakes which come when the trial and error method is substituted for education.

Third, postgraduate study should teach the student what resources communities must provide to keep their people well, so that she can guide her own industrial community groups wisely in the development of such facilities; and on the other hand she must learn how best to use these resources, once established, for the good of the individuals for whom they are planned—how the various health and social agencies are related to each other and to the whole field of public health nursing.

Fourth, since the work of any public health nurse is largely that of teaching, she must be taught how to teach more effectively, for long ago we exploded the theory that good teachers are "born."

Fifth, the work of the public health nurse concerns itself always with people—attempting to change their habits to conform to the knowledge of science—and this means that she must understand and like them if she is to be successful. She needs to be helped to a better understanding of them, and of herself as one of them. Psychology and mental hygiene contribute much to her increased effectiveness.

Sixth, but perhaps most important of all, a postgraduate period of study offers opportunity to practice in the field the work which the nurse will be called upon to do later, but under the guidance of nurses who are themselves experienced in the arts of their profession, thus gaining proficiency without exploiting in the process. Approximately half of the time of the postgraduate course is devoted to this in an attempt to furnish experience not only in the student's prospective field, but in all the various types of service open to the public health nursing profession, so that in addition to gaining proficiency in her own work, she will have an understanding of the responsibilities of the various community nursing groups with whom she will develop a close coöperative relationship. Too much importance cannot be placed upon the value of this field work under supervision; for skill in any profession dealing with people cannot be learned merely by reading about it. It takes practice, and much practice, to give proficiency.

For the nurse who knows definitely that she is to enter or return to a specialized field, such as school or industrial nursing, the postgraduate courses try to give opportunity to study the problems peculiar to those fields. In the case of the nurse entering industry, time should be given to the study of industrial hygiene, safety, and sanitation, and to consideration of such problems as those of industrial relations. In this fashion the student is trained not as a specialist, seeing only her little field, who if her position is suddenly closed to her is fitted for nothing else, but as a member of an ever enlarging profession, able to seize whatever opportunity for service presents itself. Education becomes then not a luxury, a superimposed accessory, but a part of life itself.

No one claims for a minute that postgraduate study is a cure-all. It cannot create a strikingly successful public health nurse out of a person who lacks adequate elementary education, or who dislikes working with people. Because such types — unsuccessful wherever they work—often crowd the college class room in vain effort to better themselves, without result, college courses often are judged as of little value. Given a person of fair personality, sufficient preliminary education, and a real desire to be of service to people with whom she genuinely enjoys working, postgraduate study will prove a short cut to professional attainment which in the long run is economical to both employer and nurse. The time is

past when any industry can afford to engage untrained personnel and educate them at company expense. Mistakes are too expensive, unproductive work too costly. In most instances the well prepared nurse would ask no higher salary than that which industry is already paying; at least such industrial salaries as have come to my attention have compared very favorably with those offered by community health organizations.

The employer who thinks that he has too few employees to warrant the salary of a well-prepared nurse often compromises by taking an untrained person whom he considers less expensive, or puts the nurse at part-time work in other departments of the plant, or, most commonly, goes without public health nursing service altogether. Far better than that of satisfying one's self with makeshifts, is the plan sponsored by the National Organization for Public Health Nursing, whereby small industries buy service at an hourly rate from the community public health nursing agency. For then they secure not only the hours of service arranged for, but in addition, if the agency is a good one, qualified nurses properly trained and constantly supervised, who bring to their work in addition to nursing skill, a knowledge of the community—its health needs and plans—who can fit the needs of the wage earning group into the picture of community and family health.

In conclusion, let me say that in this stage of evolution of the public health nursing profession, no industry can afford to employ any but the best trained nurse obtainable; and no nurse who desires to enter industry can allow herself the "luxury" of going untrained, if she values that sense of professional integrity which gets its satisfaction from knowledge of work well done, of service rendered to the best of one's innate ability.

THE GRADING COMMITTEE PLANS

The Committee on the Grading of Nursing Schools announces the following plans for the future:

1. To continue its work for two more years if funds can be secured for that purpose. The Committee believes that to stop the work at this time would leave several important projects unfinished.

2. To make a second grading. This will make it possible for schools to discover how much progress they have made since the first grading two years ago. All schools listed on the Accredited List, recently published by the National League of Nursing Education, will be invited to take part.

The Committee has agreed that no white list or black list based on this second grading shall be published at this time. It is, however, the present hope of the Committee that, when the study is finished, it may be possible to compile the results in a series of educational comparisons which may be made available to individuals who ask for specific information.

3. To formulate what may be thought of as minimum standards, which every school of nursing must meet if it is to call itself a school.

4. To publish before the end of 1933 a final report, signed by the full membership of the Committee.

5. To publish by the end of 1933, a practical handbook on the methods of grading which have been evolved through Committee experience.

By carrying through these various projects, within the next two years, the Committee believes that it will have met, in so far as is within its power, the chief needs of the nursing and allied professions.

The Committee feels fortunate in having secured for a limited period the services of Ethel Johns, R.N., who will make the necessary field contacts and will take an active part in preparing material for the final committee report. Miss Johns has just completed an important service of a somewhat similar kind in connection with the School of Nursing which, under the direction of Anna D. Wolf, is now being organized in connection with the New York Hospital–Cornell Medical College project.

Diversion for the "Shut-In"

By DEE NIXON

Staff Nurse, Metropolitan Life Insurance Company, Belleville, Illinois

AT first thought one might say that the subject "Diversion for the Shut-In" could be disposed of in three words: "Buy a radio." No doubt the perfection of this invention has brightened many a weary, lonesome hour for the shut-in. Sanatoria and hospitals have been quick to seize this opportunity to link the individual who must live a restricted life with the wider interests of the general public. The shut-in needs to have contact with his neighbors and friends and the world at large, as the old jokes on eavesdropping over the country telephone testify. In our rural community we used to tell a tale of old Mr. Jones who had been crippled for months with rheumatism. He soon became an habitual listener to all conversations over his five-party line. His neighbors were aware of this and rarely resented it. One day, however, two women were trying to discuss plans for a farm meeting of importance and found the connection more than usually poor. Finally one woman remarked, "I believe if Mr. Jones would hang up his receiver, I could hear what you say." "I thank you, ma'am; I hain't got my receiver down," and bang up it went. Old Mr. Jones was forced to use the means then at hand to satisfy his need for human fellowship. Now he twirls the radio dial and "listens-in" on the whole world without fear of offense. Is it any wonder that we think first of the radio for the shut-in's diversion?

But our plans for the invalid, convalescent, or handicapped, indeed for anyone who is confined within four walls for long periods of time, must include more than diversion. Even sick folks like to have something to show for their time and effort. Mental and physical creative work must be planned that will do much more than entertain or while away time. The invalid—especially the chronic invalid—must be helped to adapt his life to his limits. Not only must he learn how little he can do, but how much he can do, so that he can live even his comparatively meager life to its fullest.

Mental hygiene workers all agree that hand work is helpful in acquiring healthful mental attitudes. All of us need our minor as well as major outlets. Mrs. Calvin Coolidge writes in a recent article that when she lived in the White House she kept a bit of embroidery on hand to pick up in times of mental stress. Sometimes the physically well person finds a long walk necessary to work off a fit of spleen. Abraham Lincoln preferred a handy wood pile. Some of us scrub the kitchenette floor; clean out the back of the car; rearrange a file box or repack our old black bag. In doing things with our hands we find relief from worries which, themselves, cannot be dissipated. One of Gene Stratton Porter's stories, "The Wood Carver of Olympus," is based on this need and the help that hand work gives.

So we will plan with our invalid some type of hand work that recognizes his capabilities. We begin, if possible, with a taste already acquired and work gradually toward other plans. With the men, such projects as making small toys, intricate ship models, reed baskets, carved picture frames, tinfoil pictures, jig-saw novelties, hooked rugs, and pieces of light furniture, all find favor. Women are more apt to like embroidery, painting, darning, quilting and weaving, but many men become expert in these supposedly feminine arts, just as many women trespass on the men's domains. Perhaps it is more natural to ask the shut-in woman to do some of the simpler household tasks

such as peeling vegetables, patching, sewing, etc., but I have known men to become excellent cooks though chained to a wheel chair. One man, in his desire to be of help, ordered supplies, and gradually even planned the meals for a high school cafeteria which his wife managed. "Did they eat all the goulash?" he would telephone after lunch. "Shall I order more bread and butter for tomorrow? I found a new recipe for a pudding which sounds good." He had plenty of time to think up good things to eat and plenty of time to scout out bargains in food by way of the newspaper and telephone. A busy, useful—yes, happy life—because he found a way out of his restrictions. No useful task should be overlooked, because it is through the feeling that he is still of some real help in the world —really needed—that the invalid gradually accustoms himself to his less active life.

Sometimes when we see a handicapped patient toiling for hours over a bit of work the normal person could finish in a few minutes, we are tempted to take it from the patient and do it ourselves. A favorite aunt of mine, who for years never moved a step without her crutches, convinced me that such help may be misguided and often undesired. Once I saw her cleaning her kitchen floor with her body prone across a chair. Her stiff knees would not allow her to stoop or squat. Pushing the pan of soapy water ahead, she scrubbed the floor, getting up every few feet to move the chair with the aid of her crutches to an unwashed spot. When I asked her to let me do it, saying I could finish it in fifteen minutes, she said, "Yes and it may take me an hour, but I want something to do, and my hour is not worth as much as your fifteen minutes—if you don't waste it!" Clear thinking lay behind that statement, brought about by years of adapting herself to her handicap without giving up.

This brings us to the need for mental stimulus, the satisfying of which also must be planned. Hand work and crafts of all kinds are needed, suited to the various degrees of acquired skill, but no less must we make possible hours of reading, music, interesting talks and other methods of arousing new thoughts and ideas.

Books of travel and adventure are found to be helpful for they carry the patient mentally into new and interesting places, where he may forget for the time his own troubles. Of course, we can resort to the radio again for worthwhile lectures, classes, concerts, discussions, political speeches, and programs of world-wide interest. The radio helps the patient to think along the same lines as his friends and neighbors and to feel under no handicap when conversing with them.

A simple hobby, such as bird study, can grow into an absorbing interest. David Grayson's "Adventures in Solitude" brings this to our attention again. From a wheel chair, with a pair of field glasses, a bird guide and a notebook, a friend of mine became an authority on birds. Days spent on the porch or at the windows overlooking a swamp, a briar patch and an old orchard, gave him the chance to accumulate valuable data on bird habits.

Many of the suggestions we have made for the chronic invalid may be adapted to the convalescent with this difference in mind: The chronic invalid must be taught to make the most of his capabilities and accept his limits, while the patient slowly gaining strength from a long debilitating illness can look forward to living a normal life.

Habits of helplessness acquired through a period of sickness may carry over into the "getting well" time farther than is good for the patient. It is natural for one to like the attention showered upon him at such times and the patient may prolong his inactivity unconsciously or consciously. Perhaps a change of room is one of the first steps we may take to help the patient regain his normal independence. If this is not possible, a rearrangement of furniture and curtains in the sickroom

will help. Remove all signs of illness as soon as possible. Do not give him constant and unnecessary attendance. Instead, give the patient some responsibility and ignore his "hang-over" of peevishness or helplessness. Direct his thought to the future by planning a definite day for a move to be made to the window, to the living room or the garden. No one can forget the thrill of the first outdoor trip after being shut within four walls for weeks and weeks. A daily schedule helps to pass the time more quickly. However, we must use discretion in suggesting the steps to recover strength and interest in life. Just as an overloaded tray may upset the slowly returning appetite, so may an overloaded daily program cause a mental back-step. Normal judgment and a sense of proportion are not to be expected in the convalescent; he must be guided, sometimes checked, and often urged, as he walks up his road to health.

The restricted life of the aged often is brightened by the companionship of little children. The last of life and the first have a peculiar affinity for each other, and it is rare to find a grandmother or a grandfather in the home who is not the children's favorite companion. Perhaps it is wise to suggest that older people tire easily, so the restless energy of children must be curbed, or at least the intervals spent with the shut-in must be limited in time.

We must not forget, in all this discussion, the shut-in child. I often wish Robert Louis Stevenson's nurse had written a book for us on the psychological care of the invalid child. From his poems we glean a few hints of her ingenious ideas, such as:

> "My bed is like a little boat,
> Nurse helps me in when I embark." *

She helped him live within his limits and kept him happy. But she also gave him stimulating tasks, so that his mind made leaps and strides in spite of his weakened body.

Anything that will amuse or distract a sick or nervous child will help in his recovery. Patience and understanding must be exercised with the well child, and to how much greater an extent during sickness or disability. Wise planning of the sick child's diversion is necessary. There are many games that can be enjoyed by a child in bed and many methods by which the sick one's time may be happily employed.**

A travel scrap book is a diversion greatly enjoyed by children who are old enough to have studied geography. The planning of the trip, hunting the pictures, cutting them out, and arranging them in a scrap book gives the child a number of different things to do, thus holding his interest. The pictures may be found in magazines and in booklets which railroad and steamship companies use to advertise tours. I have known children to spend weeks in making such a scrapbook and then greatly to enjoy showing it to others.

Writing letters to friends, using cut-outs, printed words and pictures, working puzzles, making and illustrating rhymes are all interesting.

For construction work we have a long list for children—burr toys, walnut shell boats, pea and toothpick furniture, doll houses, clay modelling, painted book marks, window wedges, raffia mats and bags, willow whistles, pin wheels, crocheting and knitting.

Most boys like to make a telephone with one end near the bed and the other in the kitchen or wherever his mother is to be found. The telephone is made by using two cylindrical boxes without tops or bottoms. Over the end of each box stretch a piece of strong, heavy, tough paper and tie securely. Grease the paper lightly. Carefully punch a hole in the center of each paper cover, and pass a long cord through these holes with a large

* See also "The Land of Counterpane."

** "Hospital and Bedside Games," Neva Boyd, 1919 Cullerton Street, Chicago, Ill., 35¢; "Pastimes of Sick Children," Mary Ann Hope Whitten, D. Appleton & Co., N. Y. City, $1.25. The National Recreation Association, N. Y. City, will furnish further references from which games may be adapted for bedside use.

knot inside against the paper. Telephoning from one person to another can be done over quite a long string, if this is kept taut. Each box acts alternately as transmitter and receiver.

The making of toys is usually more fun than playing with them afterward, though the complete toys are often treasured. Here we have a chance to teach unselfishness, by having the child make little gifts for others, perhaps for those less fortunate than himself.

The very tiny invalid must, of course, be entertained. He must be helped with his block building and picture book. A wise nurse will make a game or play of everything done for her small patient.

When we worked in the children's ward we learned that a child soon adapts himself to the hospital environment. After the first few hours there is little discontent and no worry about the future; only patient acceptance of pain, dull surroundings and loneliness. So the problem with the child is infinitely more than keeping him amused. He must grow mentally as fast as he is able. His knowledge must be constantly widened and his interest stimulated so that he may take his place with his playmates when his period of inactivity is over. If he must live under a handicap always, he must be helped to find compensation. Such children were Stevenson and Roosevelt.*

The world has been made richer in many ways by the "shut-ins," and our care of them should always bear this comforting fact in mind. Dr. Pitkins says: "Life is an adventure, not a story that is told." Why not make even illness an adventure—a story in the making?

* See "Roosevelt's Letters to His Children," edited by Joseph Bucklin Bishop. Charles Scribner's Sons, N. Y. City. $2.

HOME RELIEF IN NEW YORK CITY

New York City's tax supported home relief work is now well under way. The Department of Public Welfare has opened 79 branch offices of its new Home Relief Bureau in as many public schools—one school in each police precinct, excepting those precincts covering parks or other non-residential territory.

The Department has made an arrangement with several thousand groceries which will simplify the task of the Home Relief Bureau and will provide food for the unemployed with the least possible delay and confusion:

Persons eligible for home relief will receive orders on local authorized food stores, each order to be signed and countersigned after the manner of travelers' checks. Holders of these orders have all the rights of a cash customer and must be treated as such. Goods selected by them must come to the face value of the order, and storekeepers are under no circumstances to give change in cash to the customer or send merchandise C.O.D. The grocery order is to be signed at the store by the customer, and this signature must correspond with the identification signature already on the ticket.

There is a coupon attached to the order and this the storekeeper detaches and keeps as evidence of the sale. Cigars, cigarettes, tobacco in any form, beer, near beer, soda water, candy, pies and cakes must not be sold to order holders. These are considered luxuries, and under present conditions cannot be supplied.

The basis for relief-giving and for the allocation of cases between public and private agencies recommended to Commissioner Taylor by the Welfare Council's Coördinating Committee, serving as the Commissioner's advisory committee on home relief, is outlined in the following:

While supplying necessities of life, at the same time every effort should be made to reëstablish families on a self-supporting basis.

The standard budget recommended should be used as a basis for granting allowance, modified according to special needs.

Except in special cases such as illness, the income of a person who is employed to the extent that is normal for him should not be supplemented; and such circumstances as expectation from insurance or adjustment of insurance should be taken into consideration.

To protect children from neglect, cruelty, and the overt acts of psychotic individuals, such conditions should be reported to the proper authorities.

Registration at a non-profit employment agency should be strongly urged upon those members of the families under care who are legally of age to work and physically able to do so.

Information about health, educational, recreational, and character building facilities should be given to families under care of the Home Relief Bureau.

Families under active care of private agencies should remain so for the present.

As to cases formerly under care of private agencies, but now closed, decision should be made by the family itself and the agency concerned as to whether the case shall be reopened by the private agency or referred to the Home Relief Bureau.

Families may be referred from the Home Relief Bureau to private family agencies for special services. These agencies may assume full responsibility for relief and/or service, or may share either relief or service or both with the Home Relief Bureau.

Families applying to private family agencies and not previously known to any agency may be referred to the Home Relief Bureau.*

* As we go to press, the newspapers carry the information that New York City lacks the funds to carry out this plan of Home Relief. The editors considered tearing up this statement, and then decided that the plan as outlined was sound, and the fact that New York suffers depression pains might be a comfort to other communities.—*Editors.*

LEADING ARTICLES IN THE AMERICAN JOURNAL OF NURSING FOR FEBRUARY

Antitoxin Treatment for Erysipelas.....	Douglas Symmers, M.D.
The Nurse in Erysipelas.....	Caroline Busacker, R.N.
Fifty-fifty Coöperation in the Omaha Registry.	Marie Stuhr, R.N.
The Patent Medicine Story.....	Margene Faddis, R.N.
A Nurse's Search for Nursing History.....	H. W. M.
A Nurse Among the Heroes of the Yellow Fever Conquest.....	Leopoldine Guinther, R.N.
Nursing Care of Orthopedic Children.....	Maude Parson, R.N.
Things New in the Treatment of Lobar Pneumonia.....	Wilhelmina Whisner, R.N.
A Newer Concept of Weaning.....	Katherine B. Oettinger
Methods for Stimulating Employment.....	Emma P. Collins, R.N.
Milk in Many Forms.....	James A. Tobey, Dr.P.H.
Value of Standardizing Agencies.....	Roy W. Bixler
Disinfection of Clinical Thermometers.....	Virginia Ryan and Virginia B. Miller, R.N.

Chippewa Indians in Rural Minnesota

By ADELIA L. EGGESTINE
Supervisor, Minnesota Chippewa Indian Nursing Service

ONE of the prime functions of the public health nurse is to convince people that the application of modern science in everyday life is more valuable to them individually and collectively than tradition and superstition. In working with the Indian, this is certainly the nurse's greatest function. Her task is the more difficult because up to rather recent years the Indian's experience with those who tried to teach him better ways proved most unprofitable to him, thus forcing him into confusion or complete distrust. Moreover, his traditions and superstitions are still an intimate part of his present everyday life. Not much has transpired to prove to him that the new ways are really better than his own old methods and beliefs. Mrs. Ruth Muskrat Bronson, Chief Guidance and Placement Agent, United States Indian Office, Kansas City, Missouri, herself an Indian, expresses the consensus of opinion of those who understand the Indian and his problems when she says: "The day has come when the Indian can no longer live in a separate civilization no matter what white or Indian may think of it." Thus the century-old problem of preparing the Indian for assimilation into the great American melting pot is still a very vital one today. The Indian Public Health Nursing Service of Minnesota has undertaken to aid with one phase of this problem; namely, that of helping the Indian to become a healthier citizen, fit to assume responsibility toward his fellow men, community and government.

The Indian in his primitive state before the advent of the white man was a strong, healthy individual who met the risks and disasters of life with what seemed to him an adequate and successful adjustment. He developed a relatively high degree of moral and civic virtue. When he encountered the white man he met a wide variation in human behavior and customs. The fact that the Indian philosophy and civic organization did not include ideas of personal property, accounts for the fact that he has been despoiled even by those who were particularly interested in his education and social welfare. Too often we forget our own share in making the Indian what he is today. We expect too much of him, forgetting that permanent progress comes only through change of attitude which cannot be forced upon him either by doles, by unrestricted charity or compelling him to accept what he does not yet understand or want.

Before public health nursing was started among the Indians of Minnesota, although all medical care was provided without cost to the individual and disease was prevalent, the Indian hospitals and physicians had little to do. Therefore, two well-qualified public health nurses of Indian extraction were employed through the help of the American Child Health Association and matching funds under the Sheppard-Towner Act. The nurses were instructed to teach the Indian the value of medical and nursing service, and to provide the means for reaching these services, for it was seen that the hospital could benefit him little if he had no way of getting to it. This was in 1923. At this time it was quite necessary that the nurse have an innate understanding of Indian psychology, for without this understanding and an ability to converse in their own tongue she was often barred from entrance into their homes. At first the nurse had to establish herself in their confidence. Now the Indians are able to grasp the meaning and value to them of the service and in most sections they use the public health nursing service intelligently.

THE STATE PLAN

At present there are three public health nurses employed by the Federal Indian Office, and three employed by the Child Hygiene Division of the Minnesota Department of Health. Five of these have territories assigned to them covering most of the 13,000 Chippewas in rural Minnesota. One acts in a supervisory capacity with the function of correlating and standardizing the work in the field, assisting, relieving and developing the individual nurses and keeping the Nursing Service of the United States Indian Office in touch with problems and progress. The Sioux and Winnebagoes of the state are cared for by local public health nurses as a part of their larger programs. In this group are classed the pupils of the Pipestone School and Indians residing in Goodhue, Yellow Medicine and Redwood Counties. The ultimate aim is to consider the Indian as a part of the community and not a separate problem—and in Minnesota it is quite likely that this goal is not far off.

Through home visits, clinics, school visits, classwork and talks, the nurses teach the Indian the value of good health habits and proper nutrition, control of communicable diseases; correction of defects; sanitation; medical and obstetrical care. The Indian readily coöperates at both diagnostic and treatment clinics, at which he is given a complete physical examination, with special attention to trachoma, tuberculosis and syphilis. He receives immunization against smallpox, typhoid fever, and diphtheria, and treatments for venereal disease and dental conditions as indicated. His estimate of the value of the teachings of the nurse is personal benefit. He does not understand as yet the fundamental principles underlying her teaching, so he measures her by the results she is able to show him, personally. One of the greatest difficulties that the nurse meets in dealing with the real Indian is his silence when he does not wish to express an opinion. At such times she might just as well not try to reason with him, but wait until she finds him in a better mood, or prove her point by a method other than explanation.

The policy of the Minnesota Indian Nursing Service has always been to treat the Indian as any other citizen, forgetting and trying to make him forget that any distinction is made because he is an Indian, and making allowances only for his lack of education and understanding of the situation into which he has, often unwillingly, been forced. Without the close and helpful coöperation of the Indian Service in all its phases; of the child welfare workers of the state, and the understanding support from voluntary agencies, the accomplishments of the state nursing service would have been more limited. Examples of this general coöperation are the clinics and sanitary demonstrations held at Wild Rice Lake in September, 1929, and at Red Lake, the only closed reservation in the state, in 1930.

CLINIC AT WILD RICE HARVEST

Every year about 1,500 Indians from all the Chippewa country assemble in camps around Big Wild Rice Lake in Clearwater County to harvest the wild rice crop. Many other smaller lakes also produce rice but the large number of Indians assembling here, and the fact that in 1928 twelve cases of typhoid fever developed following the harvest, made it quite necessary that something be done in 1929 to avert a similar catastrophe. The nearby one-room district school was turned into temporary modern clinic quarters. Wells and sanitary privies were installed at the school and at the camp grounds. This clinic was arranged by the Indian Office and Minnesota State Board of Health aided through service or funds by the United States Public Health Service, American Child Health Association, American Social Hygiene Association, National Society for Prevention of Blindness, Minnesota Public Health Association, District and County School Boards, State Board of Control and State Sanatorium.

The staff consisted of seven physi-

cians, one laboratory technician, six nurses, two clerks and two interpreters. Seven hundred and ten Indians were given complete physical examinations including height, weight, temperature, urinalysis, blood pressure, examination of eyes, ears, nose, throat, teeth and chest. All women were offered pelvic examination and most of them availed themselves of the opportunity. Von Pirquet tests were made on all children under fifteen years of age, and those showing positive reactions or positive clinical symptoms of tuberculosis were X-rayed. Widal tests were made on all, and Wassermann tests on all over fifteen and on other suspects. Tests for tularemia and undulant fever, and examinations of sputum were also made. Medical and social histories including family history, home environment, economic status, history of communicable diseases, and of immunization against diphtheria and smallpox were taken. Following the clinic the charts were studied by the clinic physicians and their conclusions and findings tabulated by Dr. E. C. Hartley, Director of the Division of Child Hygiene, who also made a separate follow-up chart in each instance where a condition had been found which could be benefited by dental or medical aid. All the charts were then turned over to the field doctors and nurses in whose district the patient lived, and together they worked to secure for him the proper care and supervision.

LIFE IN THE RICE CAMP

It may be of interest to know a bit about the life of our Indians in the ricing camp. The rice is ripe about September first. For about five days previous, Indians may be seen coming along the byways from every direction to the shores of Big Rice Lake. Some have cars, the rear seat loaded with tent, cooking utensils, tubs, bedding and everything necessary for the harvest and camp life, or you may find them towing a boat or canoe loaded with the necessary equipment. Or a wagon and team may furnish the transportation. The whole family including the tiny baby, the grandparents, and the dogs must come to the harvest. Only canoes or light boats are allowed on the lake because others harm the stalk and much grain loss results.

Most of the families return each year to the same camp site, having left the frame of their birch bark tepee standing the previous year. Arriving at the spot the birch bark is unrolled from its winter storage place, and camp is made. Stamping barrels for threshing the rice must be made, sacks mended, canoes repaired and canals dug by which to reach the lake. Council is held as to when the rice is ready for harvest and no one is allowed on the lake until the rice is ripe and all are ready to begin. The lake is so thickly covered with rice that it looks like a huge grass meadow.

When the harvest begins, two people man each boat. One sits at the stern with two short lightweight sticks, one of which is used to bend the stalks over the side of the boat while the other is used to strike the heads so that the bearded grain falls into the boat. The other person poles the boat slowly through the standing grain. All day long in the beating sun these two work untiringly. By about four o'clock in

the afternoon their boat is full and they come to shore. The rice is carried to the camp—a half mile or so—in tubs or birch-bark carriers slung on the back. It is next spread on birch bark platforms to dry. On the following day a member of the family parches the rice. This is done by placing about a peck in a large iron kettle or galvanized tub tilted over a hot fire, and constantly stirred with a long-handled paddle to prevent burning. There is a knack in knowing just how brown to parch the rice. It is next stamped in barrels set into the ground. This is usually done by older boys, or men, wearing a " brand-new " pair of moccasins kept only for this purpose. So, with a crunching and jigging motion of the feet the husk is removed. Threshing machines have been adopted and are being used but since these break up the kernel, the hand-threshed grain is nicer. Next the rice is placed in large, shallow birch-bark pans and with a rhythmic jerk of the hands the chaff is shaken or fanned out. After three or four fannings it is usually clean. Every step of the rice-gathering process is difficult and might not appeal to us, but the Indian likes this work and will keep at it faithfully from early morning until sunset. When the yield is good, a family will realize as much as $150 from the sale of wild rice, keeping fifty pounds or so for their own use. Wild rice is a wholesome, nutritious food, comparing very favorably in food value with the other cooked cereals. During camp life usually only two meals a day are prepared. This enables uninterrupted progress of the ricing procedures. On sunny days you will see the bushes and lines around camp hung with the bedding which is aired daily.

Shortly before sunset the rhythmic beat of the tom-tom calls the weary workers to a few hours of dancing and fun before they retire for the night. So long as the bootlegger can be kept out of camp, these evening festivities are wholesome and interesting and a necessary part of the joy of camp life. But let " drink " get into camp and the whole harvesting process is so much interfered with that it becomes a vicious bedlam.

The camp season lasts about a month. It is hardly necessary to explain after this description that exposure to unfavorable weather conditions, lack of sanitary and hygienic precautions, and the busy life of the mothers, take their toll in the lives of children and also adults following each rice harvest. Each fall a new crop of babies arrives, many premature and weak because of the terribly rough roads over which the expectant mother has had to travel to get into camp. Each year, also, about nine months following the rice harvest, we have a crop of illegitimate babies whose conception is traceable to the looser morals of camp life, and the hasty blanket marriages which are entered into under the spirit of hilarity but which do not prove permanent. Some of these conditions are being improved as local and other agencies become interested in supervising camp life and seeing that better sanitary, hygienic and social conditions exist. The public health nurse in that district spends most of her time during rice harvest in teaching and supervising the families in camp.

TEACHING BY EXAMPLE

In building up the Indians' confidence in any branch of medical service, one general rule holds. About thirty-five years ago a severe smallpox epidemic wiped out about half the Chippewa tribe and medical men were sent to vaccinate, quarantine and control the epidemic. Today, when we want to " put across " an immunization program, we need only recall the value of protection against smallpox by vaccination in that epidemic and the Indian responds nearly one hundred per cent. When we were ready to undertake care of crippled children, a few cases were chosen in which results would be plainly visible, whose parents could be persuaded to let them go to the hospital. They came back into the community greatly benefited and became our best boosters in convincing other parents. With tubercu-

losis the same method is used. Due to the fact that it is hard to persuade the Indian patient to accept treatment early in the course of the disease, and because it is difficult to teach him to carry on the proper routine when he returns from the sanatorium, many again break down, and this part of the program has been comparatively slow in developing. The service for treatment of venereal disease has been progressing, and the requests for hospital maternity care and surgery are almost greater than can be handled with the present facilities.

The Indian Office provides four general hospitals of twenty beds each, only one of which does surgery, and a seventy-bed tuberculosis sanatorium. All the state institutions are open to Indians just as they are to other citizens and thus take care of many of the feeble-minded, epileptic, insane, crippled, blind, and the dependent orphans for whom the Federal Government does not provide.

LAY GROUP AIDS INDIAN SERVICE

The Indian Public Health Nursing Service of Minnesota has an organized lay group which aids and stabilizes the service. This is composed of the Governor's Council on Indian Affairs consisting of State and Indian Office officials and legislative representatives interested in Indian welfare, part of which comprise the nursing committee. The function of the former is to consider policies relating to the general welfare of the Indian in Minnesota, and that of the latter to consider and approve policies of the Nursing Service and the programs of the nurses. From each community having considerable Indian population, subcommittees are chosen consisting of workers interested in and acquainted with the local Indian problems, at least one of whom is an Indian. Thus the nurse has access to responsible Indian aid and counsel. There are seventeen such sub-committees whose function it is to keep the nurse informed of conditions and problems, in the solving of which the nurse's knowledge and training is required.

"WHITE MAN'S MEDICINE" INEFFECTIVE

However, although some of the Indians are advanced to the stage where they are definitely helpful to the Nursing Service, we still have other Indians who can not understand what it is all about and who resist the benefits that "white man's medicine" can give them. Such a one came into the experience of one of our nurses only this spring. Her patient was a man of about forty-five who had a mild case of influenza. Upon her third visit his condition had so improved that she felt he needed no further care, but she returned a week later and found to her astonishment that her patient was more ill than upon her last visit. Since he refused to go to the hospital, the physician directed the nurse to carry on symptomatic treatment. After several visits the nurse decided that all her efforts were futile. Very much puzzled, she secured the aid of an interpreter to find the cause. It was learned that the previous summer the patient's daughter had been living as wife with one of the medicine men of the community and that when fall came and the patient wished his daughter to return to school, the medicine man objected and cursed him. Consequently, when this patient fell ill he concluded that this was the curse of the medicine man and that he would die. He employed another medicine man to break the spell, but in spite of all efforts on the part of the nurse, family and medicine man he was afraid to sleep for fear of not awakening, or to eat for fear of being poisoned. After about four weeks, this mental state drove him into exhaustion and death resulted. Last fall this same nurse, however, was able to pursuade a medicine man to submit to care and treatment for a severe throat condition.

Another nurse, after a busy day in the field, returned to the office to find a request to visit Mrs. White Bear. On an old straw mattress in the middle of the floor of her low, dark, one-room log hut, she found the patient in a state of shock, surrounded by four old women saying their charms. With

the aid of a younger neighbor woman she finally succeeeded in extracting the information that, thinking the patient was to have a baby, the neighbors had administered Indian medicine but with no results. Now they thought she was dying. To the nurse it was apparent that the latter conclusion at least, was correct. Every effort to administer care was frustrated by the over-anxious medicine women, so, finally, with the aid of the Agency Superintendent, the nurse succeeded in having her removed to the hospital where, however, she died from the effects of the too drastic Indian medicine and kneading process. This sad experience taught more than one good lesson, however, for only a few weeks later one of those medicine women allowed the nurse to take her beloved grand-daughter to the hospital to have a necessary tonsillectomy.

To aid the Indian in his struggle to lift himself out of a sense of resignation to things as they are, the sense of helplessness and dependency, we are trying to increase his self-respect by recognizing his commendable accomplishments, by instilling in him a sense of responsibility for his own condition, and by teaching him to understand and use intelligently the resources and facilities which are available for the betterment of his health, education and economic welfare.

A COUNTY STUDENT AFFILIATION

Not many official county agencies offer student affiliation to schools of nursing. It is therefore of interest to find that the rural public health division of the Cook County Bureau of Public Welfare, Chicago, Illinois, of which Miss Harriet Fulmer is supervisor, is offering two months experience to four students at a time from the School of Nursing of Michael Reese Hospital. Miss Fulmer sends us the following information:

The students come for their affiliation in their senior year. The experience is elective. They wear the uniform of their own school, but the county provides plain blue coat and hat. The arm band of the Cook County public health nurses is worn on the coat. The school provides luncheon, the County transportation. All other expenses are borne by Cook County.

The students observe and assist the staff of twelve graduate nurses for a month, after which they carry their own cases, manage their districts and write their records—of course under close supervision. The County offers a generalized nursing program, including clinic experience, which the students find invaluable.

A typical daily report sheet of a student nurse reads as follows (summary only given here):

Records—Half hour
School Work—Examined, weighed and measured 31 pupils—Grade I (Corrections and defects listed)
Home calls—Old case, to deliver milk order
Emergency case—Patient run down by auto, bedside care
Prenatal call
Communicable disease—release from quarantine
School follow-up visit
Infant welfare call
Interviews with two doctors and president of P.T.A.

The county service covers infant welfare, tuberculosis, school nursing, bedside care, hospital social service, and general health supervision.

The Uniform—A Professional Asset

By BESSIE CAMERON McDERMAND

Assistant State Home Demonstration Leader, New York State College of Home Economics, Cornell University, Ithaca, New York

IN taking stock of her professional standing and efficiency, the public health nurse is likely to set down her uniform as a liability instead of making it an asset. Yet who does not turn to get one last glimpse of the dashing young lieutenant or the dignified officer of the navy? The same men in mufti would pass unnoticed. It is not the man but his clothes that make our hearts miss a beat and suggest the romance and pride of his service. His clothes express his purpose in work sincerely and consistently. If the uniform of the public health nurse is to claim any artistry or distinction, it will have to do the same thing. On this basis of expressing splendid endeavor and accomplishment, the uniform of the nurse should stand far ahead of that of any military order. If it fails, it is primarily the fault of the public health nurse herself.

Let us remember that we are continually making pictures of ourselves and that what the world knows and thinks of us depends largely upon the kind of picture we present. Much of the stuff that goes into this picture is contributed by the clothes we wear. Their line, color and texture are the major factors in the effect. The public health nurse works with people and a large part of her success depends upon their confidence in her. The wise nurse makes her clothes work for her in attaining this trust by having them express something of what her profession stands for.

The problem is to select the outstanding characteristics of the job and consistently express identical characteristics in a uniform. The public health nurse should be representative of strength rather than weakness. There should be about her a positive ability, a firmness and certain robustness of purpose. One should sense a stability of service that resembles durability. An alert readiness to shoulder responsibility should be in evidence, without a shadow of hesitancy. There must be an expression of maturity that suggests ability to take care of a serious emergency and along with this a confident ease that only dignity can give. The ideal of good health should stand out conspicuously with good sportsmanship not too much lost in the background.

Let us put these qualities in the nurse's uniform so that there will be nothing crude or immature in the result. To be a really good costume, it must not lack this suggestive power.

COLOR MAKES FIRST IMPRESSION

There is the problem of color to decide upon. It must be practical, attractive and becoming to the majority. It must be agreeable in large masses, for public health nurses *will* hold meetings! The dark values are stronger than light values and are therefore preferable for the street costume. Intense colors have an exciting, striking and brilliant quality that does not reflect a desirable steadiness of purpose, while colors too dull and muddy lack clarity and that essential sparkle of interest.

All the reds and yellows are very warm in feeling and too exhilarating for our purpose. For example, to my mind, undergraduate nurses are more pleasing to sick patients when they are dressed in light or medium blue than when they are in pink. Blue, because of its association, has the calmness, serenity and coolness that pink lacks.

In the clinic, the public health nurse may wish to cover her dark uniform with another garment. This should express the highest degree of cleanliness and sanitation and should there-

fore be very light in color or pure white.

The light colored garment used in the clinic should be made of a material that shows the sheen and immaculate quality of good laundering. Cotton crepes and their relatives may be cared for easily, but they do not express the ideal of the correct uniform for the public health nurse.

For the street uniform such colors as a clear navy blue, oxford grey, forestry green, or the greenish khaki found in some woolen materials are safe choices. A too close harmony of color, such as the combination of two shades of blue that are almost alike, creates a dull and lethargic effect and is probably not the thing we should work for. Snap and vitality are put into the costume by using a sharp color contrast. White may be used with navy blue, black and white and steel with oxford grey, and dark green or brown, and cream, with greenish khaki. In general, it is well to keep away from colors with too much brown in them. Brown does not express the cleanliness and vitality a nurse's uniform should denote. It is heavy in feeling.

Usually the most successful street uniforms have the coat and dress of the same color.

MATERIALS MAKE A DIFFERENCE

Materials should be sportsmanlike rather than elegant, and heavy enough to contradict any effect of flimsiness or delicacy. They should make up well in a tailored style and hold a press. The heavy winter coat is most satisfactory when it is made from a good grade of some standard material. A rough texture is preferable to a smooth one, because smoothness is likely to hit a "dressy" note.

The material of the dark street dress should be washable or clean well and be durable. If there are washable collar and cuffs they should have a certain crispness about the texture that expresses efficiency and alertness. Too much softness is not good.

When choosing the material for the staff dress one should remember that many types of figures will have to wear the garment. It is difficult for some to wear woolen jersey, especially the cheaper grades. A wool fabric of a firm compact weave is better.

THE STYLE OF THE GARMENTS

Not only should the material and the color of the street clothes give the feeling of strength and dependability, but this should also be carried out in the style of the garment. The silhouette should be simple without a suspicion of any artificial contortion to express frivolity.

A well-managed severity of line can be very smart. Curved lines are graceful and feminine, but not vigorous and strong. Therefore, they have no part in this uniform. The lines to emphasize are the straight ones, the long lines of dignity, the crosswise lines of strength, and the bias lines of motion.

For our purpose a widely pleated straight skirt is better than a more finely pleated one. A gored or a six gored skirt is better than a circular cut. A collar with a plain straight edge is better than a scalloped one. Long sleeves are better than short. Turned back cuffs, fairly tightly wristed, are better than flares about the hands. A tie with a tendency to width is better than a narrow thin one. Bows and lace should never appear. There should be no enrichment of tiny tucks or small broken edges. If a pin is worn, it should not be a delicate exquisite thing, but should be of good size, hardy in character with no bright and shining jewels. It might be heavy silver or dull gold and show its practical function of a fastening.*

The whole effect of unbroken line is obtained if the coat is long enough to cover the dress. In fact there should be nothing small about this coat. The buttons should be as large as the coat and owner can wear and every one of them should function. If there is a belt it should buckle rather than tie.

* *Editorial Note:* Quite naturally, we recommend the plain gold seal pin of N.O.P.H.N. membership!

This belt must be a sturdy thing with no string-like characteristics. Large pockets are more in keeping than small.

THE HAT

Perhaps the uniform hat has given the public health nurse more trouble than any other part of her outfit. Women's hats have a way of being made for individuals and not groups. A style of hat that looks well in different sizes and on different types must be chosen. It, too, can express the same smart severity and sturdy sportsman-like or military character that the good uniform coat expresses. Otherwise there will be opposing factions in this ensemble and all its distinction will be lost.

Felt is an excellent medium. Even if there is a craze for fluffy trimming the well-dressed nurse must keep it off her business hat. Nor is there here a place for perky bows or shining pins. The hat itself should have a fine line. If it is placed on the head at the proper angle and well worn, the best secret of becomingness is shared with that of the most expensive hat. If there must be trimming, let it be a simple thing like grosgrain ribbon or a leather band. Keep this trimming flat.

CLEVER ENSEMBLE MAKES THE UNIFORM

The hat, dress and coat may be ever so well chosen but the whole outfit will be a failure if the shoes, gloves, scarf, bag and other accessories do not support the main theme. We all know that in a good picture everything leads to a central idea.

Shoes are one tell-tale of our respect for health. If a person stands too much or walks too far on paper weight soles with spike heels, she may do all kinds of queer unhealthful things to herself. Consequently, such shoes do not belong with the nurse's uniform. They would look as ridiculous as dancing pumps on the doughboy in his heavy khaki. The heel does not have to be the spring heel of our childhood, but it should not have too small a walking surface. The soles should be sturdy for appearance's sake, as well as for comfort. The shoes should be no more frail looking than the coat and hat of this costume. They may be oxfords or have a substantial strap. Modified oxfords with many cut-outs and shoes with three or more straps are being used a great deal, but such shoes when worn with lighter stockings give an objectionable spotty appearance. A foot loses its smartness when clothed in such a manner. Fortunately, many well-cut oxfords and one strap walking shoes are on the market.

The color of the shoes is decided largely by that of the uniform, but they should be kept as dark as possible or the spirit of the street costume will be weakened and spoiled. The shoes and handbag should match in color and they are still more pleasing if they are of the same texture. A nurse with a blue uniform, brown shoes and a black bag is not very well put together. If the shoes must be brown, the bag should be the same.

The majority of public health nurses carry a bag that resembles a kit bag. Sometimes this is uniform for the entire group, sometimes it is provided by the individual. In either case, the bag should be as carefully chosen as any other part of the costume. Leather is preferable to fabric and it should have no small enrichments or ornaments.

Many women like to wear scarfs under their heavy coats to protect perishable collars. Not long ago I saw a public health nurse with a good looking navy blue uniform using a pastel colored chiffon scarf with a flower design. It was as ridiculous as a sailor topping his uniform with a silk hat. Flowered chiffon scarfs are a part of a feminine, dainty, flower-like costume designed for a person in quest of gayety in the midst of a festive environment. This nurse could have made her scarf a stunning accent and not only strengthened her costume but heightened its interest. She could have chosen a double silk scarf or a soft woolen one, depending on the textures of her dress and coat. An immaculate

white silk crêpe scarf would have made her navy blue costume attractive and shown her respect for cleanliness and appropriateness. She could add more interest to the scarf by using stripe insets of navy blue and a bit of red.

Just any pair of gloves will not do for the smart uniform. Cast off dress gloves with fancy stitching and wrist bands can do almost as much harm as a flowered scarf. The gloves may be made of good fabric or be of the leather sports variety. The simple pull-on type with plain stitching or hand sewing is preferable. Gloves may be the color of the shoes and bag or be a light shade, depending on the current fashion.

Even handkerchiefs should be in line with the rest of the uniform. They should be of good size and without dainty lace or embroidery. A white linen handkerchief with a fairly wide hem is a good choice. If there is sufficient cash in the treasury, an initial would add individuality.

RECOGNIZING THE RIGHTS OF PERSONALITY

While the purpose of a uniform is not to express the individuality of the wearer, her personality need not be a dead loss. Personality is determined by a varied assortment of many characteristics. One person may have an assortment that takes a stronger and more tailored type than another, but each person has a certain range allowing her to wear clothes that go just so far down the scale to strict formality and so far up the scale to informality.

The stronger and athletic types will find the uniform very becoming because it is also a true expression of themselves. The picture they present is entirely consistent. The small, dainty girl, perhaps with light coloring, may find that tailor-mades and sharp contrasts in color must be carefully handled or her personality will be overpowered. Minor adjustments may be made for her which will not interfere with the spirit of the uniform. Her belt may be made narrower, the size of the buttons decreased and her scarf made less voluminous.

THE PUBLIC APPROVES OF FASHION

Not only should clothes fit the person and the occasion, but also the times. This is particularly true of women's clothes. We do not enjoy seeing a hat of the style worn three years ago. Probably a certain psychology underlies the fashion in clothes. The changes in style may be a reflection of the way we feel at the moment. Every year brings a dominant expression with many undercurrents. These fads in no way affect the uniform, but when hats are worn pulled well down on the head, the public health nurse is more attractive if she wears hers in the same manner. If skirts are of medium length, a knee length street uniform looks outgrown. When every woman has her belt at the natural waist line, the health worker should not wear hers five inches lower.

The public health nurse who develops an understanding of how to assemble a good uniform will gain also an appreciation which will guide her in the choice of her costumes for other purposes.

PRIDE IN A GOOD UNIFORM

The successful uniform of the public health nurse must be a composite expression. It should indicate the high purposes of the profession, recognize the environment where it is worn, suggest current fashion to a degree that reflects the best of the times in which we live, and consider the individual nurse sufficiently to make her feel at home in her professional costume. Its artistry makes the nurse good to look at, and creates a pleasant attention bespeaking confidence. When it accomplishes this, it makes a contribution not many of us know how to perform for ourselves in our own costumes. Such a uniform is a professional asset.

The Columbus Cancer Clinic

By HELEN SCHAEFFER HAUGHTON, R.N.
COLUMBUS, OHIO

ON November 2, 1931, The American Society for the Control of Cancer designated the first week of November as National Cancer Week, with the object succinctly stated in its constitution "to disseminate knowledge concerning the symptoms, diagnosis, treatment and prevention of cancer, to investigate the conditions under which cancer is found, and to compile statistics thereto"; and upon these basic principles, the Columbus (Ohio) Cancer Clinic was organized in 1921 and incorporated in May, 1927. The organization was accomplished through the efforts of Mrs. Samuel L. Black and a group of public spirited citizens, who had long realized the need of such a clinic in Columbus. The clinic was founded for the purpose of combating cancer, by

Holding free clinics for the benefit of persons wishing examination, advice or treatment

Disseminating knowledge concerning the prevention of cancer, its early diagnosis and treatment

Investigating conditions under which cancer is found and by compiling statistics in regard thereto

Enlisting the coöperation of all social organizations, physicians, dentists and the laity

After organization, the cancer clinic was financed for two years by private donations from people interested in cancer and its treatment. Since 1923, the clinic has been supported from the Community Fund. It is controlled by a board of ten directors, of which Mrs. Samuel L. Black is president, and is under the supervision of a medical director. The staff consists of three examining surgeons, two consulting surgeons, three assisting consulting surgeons, five radiologists, one dermatologist, one attending physician, all of whom are called upon to give their services in the various cases. The nurses employed by the Columbus Cancer Clinic must be registered in the State, must be approved by the President and Medical Director and must be in sound physical condition.

CLINIC NURSE'S DUTIES

The working day for the nurse is from 8:00 A.M. to 5:00 P.M., with one hour at noon off duty. One half day during the week is free. Sunday visits are made when necessary. A nurse who has served one year, will be given each subsequent year, one month's vacation on full pay. In case of disabling illness, a nurse shall receive her full salary for two weeks and as much longer as approved by the Medical Director. In all other cases, leave of absence must be obtained from the President. The nurse's uniform is dark blue, with white collar and cuffs, dark blue coat and hat. A nursing bag is provided for visits requiring surgical dressings and bedside care. Each nurse is responsible for its completeness and order.

The nurse in charge conducts the clinics, which are held twice weekly. She is responsible for accurate case histories and adequate "follow-up" notes on every patient coming to the clinic for examination. The clinic at the present time employs two nurses.

Patients come to the clinic through doctors, nurses, dentists, social workers, the general public and publicity. The examinations at the clinic are free to all; however, if patients can pay anything toward their hospitalization and treatment, they are requested to do so, and if they are unable to pay, arrangements are made for their care. All cases are investigated by the nurses before arrangements are made, and in case the patient has a private physician, the clinic coöperates with the physician in making such arrangements.

The follow-up visits on cancer pa-

tients continue over an indefinite period of time; all cancer cases not requiring daily visits are visited at least once every three months and a record made of their condition. They are encouraged to report to the clinic for re-examination at regular intervals, or sooner, if any trouble occurs.

All pre-cancerous cases, that is, cases that are not now cancerous, but show conditions which should be corrected in order to prevent them from becoming malignant, are encouraged to follow the advice given at the clinic, and are visited at least once every six months by the nurses. We feel that the nurse can do a vast amount of good by tactful presentation of information and a word of advice when suggestive symptoms are disclosed.

In addition to giving bedside care, arranging for treatment, hospitalization, etc., we coöperate with all the social agencies in the city, in an effort to supply the needs of the patients. One of the most needed and desired additions to the clinic, this year, was a perpetually endowed bed in one of the hospitals and it is constantly occupied by our patients. All hospitals in the city have been very generous in hospitalizing charity patients from our clinic and this spirit of coöperation has been a great help in the accomplishment of the work we are doing.

EDUCATIONAL PROGRAM

The clinic feels that a great deal can be done in educating the public to recognize symptoms early and to consult a reputable physician. Too many patients come too late, when in many instances they could have been saved by early recognition and treatment. Recognizing this fact, an educational campaign is conducted each year. Our educational work consists in displaying in public places posters stressing the danger signals of cancer, in distributing leaflets to industrial plants, stores and public buildings, in lectures by prominent authorities and in showing films in the theaters. The danger signals stressed are:

Any lump, especially in the breast
Any sore that does not heal, particularly about the mouth or lips
Any irregular bleeding or discharge
Persistent indigestion, with continued loss of weight

ANNUAL REPORT

The following is a report of the work accomplished by the clinic for the year 1930:

Total number of examinations	692
Number of home cases referred to the clinic	16
Number of cases found to be cancer	77
Number of cancer cases—reëxamined	42
Number of cancer cases—Jan. 1, 1930	234
New cases—cancer	85
Cancer cases—reopened	1
	320
Cancer cases—discharged—Expired	51
Lost	5
Total number of cancer cases—Jan. 1, 1931	264
Number of patients referred to their own physicians	56
Number of pre-cancerous cases carried	536
Total number of clinics held	102
Total number of patients examined at the clinic	3,067

The following groups referred cases to the clinic:

Physicians	46
Nurses	28
Patients	41
Publicity	130
General public	104
Social workers	7
Board members	7
Tuberculosis dispensary	6
Clinic sign	4
Red Cross	2
City Charities	2
Veterinarian	1
State Fair	2
Insurance company	1
Betty Fairfax Column	3
District Nurses Association	1
Druggist	1
Dentist	1
Hospitals	2
Number of visits made by nurses to homes	3,757
Number of visits made by nurses to hospitals	305
Total	4,062

During the past year, we had as patients, a woman whose age is 103 and a boy of 10, indicating that cancer can strike at any time and has no age limit.

The Moline Public Health Nursing Service

A Plan of Centralized Administration

By MABEL M. DUNLAP

Director, Moline Public Health Nursing Service, Moline, Illinois

PUBLIC health nursing began in Moline in 1903 when The King's Daughters Union employed a graduate nurse to do general visiting nurse work. Under wise management and able leadership the service grew until in 1912 a second nurse, and in 1914 a third nurse, were added by the King's Daughters.

In 1919 the Red Cross Chapter decided to join with the King's Daughters in developing a broader program, and in 1920 the local Tuberculosis Association also entered the field. For many years the work was carried jointly by the three organizations, the direct management being centered in a committee appointed by The King's Daughters Union. Gradually there became evident to all three organizations, and to the office management as well, the great need for a centralized group, representing all agencies, to determine policies, formulate programs, plan budgets, receive and dispense funds.

After careful consideration and discussion the following plan has been adopted and carried out:

A board representing all three agencies has been formed.

The members of this board are chosen by each agency for three years, and the term of office of one-third of the board expires each year.

The governing board as it now stands has nine representatives from the King's Daughters, who carry half the budget; six from the Red Cross, carrying four-tenths of the budget; and three from the Tuberculosis Association, carrying one-tenth of the budget. The president of The King's Daughters Union, the chairman of the Red Cross, the president of the Tuberculosis Association, and the director of the nursing service are ex-officio members.

The board has incorporated, formed its own organization, adopted by-laws, elected officers, planned the budget, and has established an accounting system.

On the first day of the month each supporting organization pays to the treasurer of the board one-twelfth of its share of the annual budget.

Income from other sources is apportioned in the same ratio as the budget, and is placed to the credit of each organization.

The treasurer of the board makes a monthly itemized report to each agency on expenditures of its share of money, and any balance to its credit.

This board functions as any directing group would do. The officers and members are interested and enthusiastic and all committees are active. Continued absence from meetings, without good reason, constitutes a resignation from the board, and a successor may be appointed by the agency represented.

The establishment of this definite, centralized source of authority, its personnel carrying full responsibility, to represent and act for the agencies, has given the entire service a more dignified, businesslike position among other agencies and in the community at large. The bookkeeping is not too complicated, and any extra work it may entail is more than compensated by the advantage of centralization of all matters pertaining to the service, financial and otherwise.

The supporting organizations are getting a clearer conception of the city-wide and rural program, and there is no evidence of any misunderstanding or jealousy among the members. This

is particularly noteworthy when one stops to consider that the King's Daughters originated and fostered the work through the trying pioneer years, and that they are deeply attached to it by tradition, sentiment, and loyalty. Only a great community spirit, generous in thought and wish, could have given up personal wishes for the greater good.

Miss Mabel Dunlap of the Moline Public Health Nursing Service and of the Upper Rock Island County Tuberculosis Association has asked me to tell what the Rock Island County Home Bureau is doing for the Tuberculosis Association.

Last year, Rock Island County Home Bureau wished to render some constructive service to the various communities in the county and to further that part of its aim which says that every home should be "physically healthful." Therefore, the organization was quite delighted when Miss Dunlap asked for support and assistance in rural school health inspection. A health chairman was appointed in each Home Bureau Unit throughout the county. Her duties included notifying the teachers and parents of the date of the visit of Miss Jewel David, the tuberculosis nurse, urging the parents to be present, and personally assisting the nurse in the health inspection. Whenever possible, the Home Adviser accompanied the nurse to the various schools and assisted with the work. A check-up on the inspection plan was made with the following results noted:

Number of schools	39	(each school inspected twice)
Number of hours	179½	
Mileage	1,329	
Number of pupils	1,190	(inspected twice)
Number home calls	16	

Defects Found and Corrections

	Defects	Corrections
Eyes	188	9
Ears	66	1
Nose and throat	1,106	2
Teeth	717	142
Glands	256	...
Skin	20	...
Underweight	263	...
Orthopedic	7	...

This project opened a new activity for the Home Bureau and all members feel that it is a most worthy piece of work. The Home Bureau also had charge of the sale of Christmas seals in the rural schools last year.

Under the direction of its County Health Chairman, Mrs. George B. Coe, Port Byron, the Home Bureau is assisting with the work again this year and promises to support the work of the Tuberculosis Association throughout the future. So interested have the individual members of the organization become, that each one is making a bed pocket to be presented as a Christmas gift to the new Rock Island County Tuberculosis Sanatorium.

Through the agency of the Tuberculosis Association, the scope of Home Bureau activities has been broadened and its members feel that they are contributing a real service.

FERN CARL,
Home Adviser, Rock Island County Home Bureau

The Office Secretary Speaks

By LILLIE M. NEILSON

Office Secretary, Public Health Nursing Service, Moline, Illinois

Editorial Note: We cannot remember ever before publishing comments from the office secretary of a public health nursing agency. Who is in a better position to know us—at our best and at our worst? On whom does the responsibility for meeting the public fall more heavily than the secretary who takes the nursing calls, receives complaints, explains delays, calms the frightened family, unearths minutes and correspondence for harried board members, reminds us of appointments—in short, is the pivot on which the machinery of our service turns? We are glad to have Miss Neilson's impressions of us, both literary and artistic.

BEING thoughts—some old, and others quite new—that have come to this secretary in connection with the work of the public health nurses and her part in it "in a little mid-western town where plows are made."

It has been said of public health nursing, "The corridors of our hospital are the streets of the city." As far as this organization is concerned, our office comprises the Universe from eight A.M. until five P.M.

What is public health? Well, from our viewpoint, it's just about everything. It's Johnnie who needs a tooth pulled, and his father who needs work, and his mother who needs glasses—not forgetting the records which must be made for them. It's old Mrs. V. who is a character fit for a book, and the premature baby whose mother and father were married after its birth, and the little crippled boy who needs braces, and the records we must make for *them*. It's the ex-service man who comes in asking for assistance, and the stray dog that wanders into the hallway, and the drunkard to be shooed out of the building, and the telephone calls that must be taken, the funds to be taken care of, the appointments to be made, the magazines to be catalogued, and—and—in short, everything.

To us it is interesting to speculate on how in the world some families would be able to exist, let alone keep house, without the public health nurses to turn to in their almost constant troubles. If Mary gets chewing gum in her hair, or Sonny stubs his toe, or the coffee boils over, or father oversleeps, or the cat has kittens, "call the nurse"! We feel that the public health nurse is a wonderful institution—more power to her. She needs it!

CASES

Cases are most interesting, and we never know what queer, outlandish requests may come to us over the telephone. Some are quite ordinary, others wildly exciting. Humor can run riot, but then, without warning, comes cruel tragedy, and we realize our helplessness when we buck up against the "ordained scheme of things."

Shall we ever forget the morning that Mrs. C. stumbled in, the tears making little rivulets down her mottled face? With each rub of her dirty hands, the streams became a little muddier. "Little Johnnie [the baby in a family of five children] died last night. He didn't feel very good, and we fed him wienies, and he died!" It was 110 in the shade, and they fed that little eighteen-months-old babe, sausages! Of course, we sympathized with her as best we could. Also, we were sure in our own mind that in less than a year there would be a successor to Johnnie—and there was. To the onlooker, a reluctant humor touched even this vital sorrow, but only a few years later stark tragedy crowded humor completely out of the picture, leaving us to wonder "why"! The oldest son in this same family was snatched from them by drowning, just when he had reached young manhood, and could carry his share of the family load.

Then there was the amorous, hand-

kissing Frenchman, whom we suspected of having T.B. He'd sidle in, and be at our side before we even knew he was in the neighborhood. When leaving he'd extend his hand, and since we must be polite and shake when invited, we gingerly would put forth our "north paw," only to have the innocent, unoffending member not only shaken, but kissed! After each of these dramatic leavetakings we treated the "honored" paw as an isolated member of our anatomy, and only when Frenchy finally left town was the hand brought back into the fold.

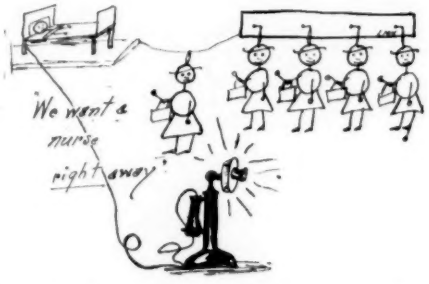
We mustn't forget Mr. F. who comes ambling in every now and then to get "ten-cent cat-liver oil for de babies." Each time we repeat, "Oh, yes, you want *cod*-liver oil," but to no avail. He continues to desire "cat-liver oil," so we continue to dispense "cat-liver oil," and he probably thinks that his infants will be imbued with at least seven of the nine lives of the "health-minded" feline that gave up its liver for the good cause.

O. B. CALLS

O. B. calls! What harrowing pictures those letters bring to mind. We are sure we add years to our life as we dash from directory to telephone book to telephone, in an effort to locate a nurse in the district. Why is it that such calls always come just after all nurses have left the office? And when you finally get word to a patient's home, through a kindly neighbor (you know, of course, that when you want to locate a nurse none of her particular patients has a telephone), why is it that the nurse has always just gone to her next case? We want to know.

And why, oh why, do people call in with the fixed idea that we have nurses hanging in a row on the wall, like so many tags, so that all that remains to be done is to pull a string, and a nurse will come scooting along on the telephone wire, and be in the home before the receiver is up?

We made wonderful time once, and snatched the nurse out of her district and down to a home to help the doctor



with a delivery in less than ten minutes. She arrived just as the doctor drove up, and together they dashed madly in, only to find the patient had no idea of having a baby that morning—she was not even pregnant! The welfare worker who had called the doctor and nurse must have thought that a sick Mexican woman meant only one thing—a baby.

RECORDS

A large part of the office secretary's job is to transfer the interesting experiences and achievements of the staff onto paper in the shape of records and statistics, with figures and graphs depicting to the board of directors and the public the scope and progress of the work.

As we all know, statistics are vital, and in order to be vital must be accurate, but—have you ever "lost" a couple of hours among the six reports you are trying to total, only to find (after hours and hours of frantic search on a sweltering hot day)—that you have read the nurse's "1" as a "7"—and—oh, you have? Then you understand.

And what a thrill to work on our annual report, with hundreds and hundreds of figures, and have the cases and hours come out right the first time we add them up! (It really happened once here.) As we struggle, it is borne in upon one that one of those hundreds of cases is old Mrs. G. who smokes a pipe; and one is the premature infant, nurtured and cared for until he is now a big, lively baby boy; and another is the pathetic T.B. patient who is fighting to the last; and still another, little Sammy, crippled from infancy, now

wearing braces and joyfully looking forward to a useful manhood. Oh, well, we decide, reports and records aren't so bad after all.

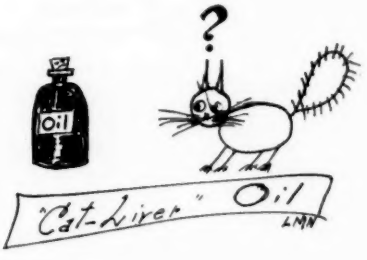
FUNDS

Webster defines a "fund" as "a sum of money." We have great admiration for him, but we feel that he didn't know the half of it. The funds we have taken care of! We want to take to our heels and run when we hear any one say, "We'll just have a fund for that—Miss N. can take care of it." Take care of it! Why, we have nursed so many funds along from infancy, through a sickly childhood, to robust maturity, that we might almost qualify as a special nurse for funds.

CURIOSITY AND PERSONAL BENEFITS

The office secretary must have a healthy curiosity regarding her job and all things even remotely connected with it. She never knows when she will be asked innumerable questions regarding the work (past, present, and future), regarding the building and all the organizations in it, or regarding the intimate details of how to bring up children. Nor must she seem to hesitate a moment, no matter what the question meted out to her.

This office secretary has grown up in the work, having come directly from high school. We have had experiences that we never could have had in any other line of work. We have learned to meet people as "folks," and are equally at home with the president of the United States Chamber of Commerce, and the hobo who wanders into the office. We have a working knowledge of health standards, sane living, and care of the sick. We have been unusually fortunate in being invited to the Quad-City Public Health Nurses' dinner meetings, and have heard many interesting, inspiring and educational talks. Through outside work for the director, we have knowledge of the nursing organizations, the leaders in the nursing profession, and the various phases of the profession. Last, but not least, we have access to the health and nursing books and publications. Yes, working with a public health nursing staff is a liberal education, and, in our humble opinion, public health nursing is the broadest and most broadening field in the profession.



ACTIVITIES *of the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, INC.

Edited by KATHARINE TUCKER

THE N.O.P.H.N. BIENNIAL PROGRAM

The preliminary program for the joint sessions was announced in the January, 1932, number of PUBLIC HEALTH NURSING. The complete program of all sessions will be given in the March issue. In the meantime, our members may be guided in their decision to attend the Biennial by reading the following preliminary N.O.P.H.N. program:

N.O.P.H.N. GENERAL SESSIONS

"Public Health Nursing Education"
- Recent developments in staff education
- Recent trends in post-graduate courses to meet the demands of the field

"Board and Committee Organization"
- Review of Board Members' Manual
- Variations in Board and Committee organization from the standpoint of:
  - County organization
  - Small organization
  - Large organization

"Board and Committee Challenges"
- What to know and how to find out
- Demonstration of a model board meeting

"Team Play Between Official and Non-official Agencies"
- Relation of state public health nursing service to county and local services
- Nursing relationships in the county health unit
- Factors to consider in working relationships in official and non-official services:
  - From the official viewpoint
  - From the non-official viewpoint
- Advisory committees for city and county official agencies

"What Do Records and Statistics Tell?"
- What is basically essential and why
- Use of records and statistics by local agencies
- Use of records and statistics for special studies

"Challenges"
- Assumptions, Facts and Fallacies in
  - Maternity, infancy and preschool service
  - Communicable disease service
  - School nursing service

"Cost Analysis"
- Principles and practices in public health nursing
- Computing the cost of a visit

"The Effect of the Economic Situation on Public Health Nursing"
- Report of the Economic Emergency Committee
- Relationships between public health nursing and social work
  - In cities
  - In rural districts

In addition, the program provides for business meetings of the N.O.P.H.N. and each of its sections, a publicity clinic, a luncheon meeting for staff nurses, teas for board members, and round-tables on special subjects. There will be a meeting of representatives of every type of state organization concerned with public health nursing, an all-day conference of the course directors, and an all-day conference of state supervising nurses.

The N.O.P.H.N. would appreciate a credit line in tiny print when N.O.P.H.N. posters or printed material are adapted for local use. This does not apply to the N.O.P.H.N. seal.

Look for complete Biennial program, last minute instructions, and full description of Texas public health nursing activities in our March number!

The N.O.P.H.N. Nominating Committee presents the following list of candidates for officers and directors of the N.O.P.H.N. for the biennial period 1932–1934.

Members of the N.O.P.H.N. are asked to vote by mail to facilitate the checking of names preceding the Biennial Convention. Each full nurse member and each lay member will receive, a month before the Biennial, a ballot similar to the one on this page with complete instructions for voting printed on the reverse side. Election of officers will be announced at Biennial.

MIRIAM AMES
Chairman, N.O.P.H.N. Nominating Committee

N.O.P.H.N. BALLOT

President

☐ Sophie C. Nelson ☐ .....

Check one name. The candidate receiving the largest number of votes shall be declared elected President.

Vice-President

☐ Ruth Houlton ☐ Winifred Rand

Check one name. The candidate receiving the largest number of votes shall be declared elected Vice-President.

Second Vice-President

☐ Mrs. Roessle McKinney ☐ Mrs. C.-E. A. Winslow

Check one name. The candidate receiving the largest number of votes shall be declared elected Second Vice-President.

Treasurer

☐ Michael M. Davis, Ph.D. ☐ .....

Check one name. The candidate receiving the largest number of votes shall be declared elected Treasurer. (According to the By-Laws the Assistant Treasurer is elected by the Board of Directors.)

Directors—Nurse Members

Vote for four:

☐ Ann Dickie Boyd ☐ Marion G. Howell
☐ Helen S. Hartley ☐ Sara Barclay Place
☐ I. Malinde Havey ☐ Marion W. Sheahan
☐ Marguerite A. Wales

Directors—Sustaining Members

Vote for four:

☐ Mrs. Chester Bolton ☐ *Nomination pending*
☐ Mrs. J. L. Brock ☐ Mrs. Saidie Orr Dunbar
☐ Raymond Clapp ☐ Mrs. John G. Priedeman
☐ W. F. Walker, Dr.P.H.

Candidates for Nominating Committee for 1934

Vote for three:

☐ Alice G. Bagley ☐ Eva F. MacDougall
☐ Gertrude H. Bowling ☐ Eleanor Stockton
☐ Cornelia Van Kooy

BIOGRAPHIES OF CANDIDATES

Bagley, Alice C.

Graduate, Cleveland General Hospital; Western Reserve University. Positions held: Supervisor, Visiting Nurse Association, Cleveland; Supervisor, Henry Street Visiting Nurse Service, New York; Supt. of Nursing, Instructive Visiting Nurse Society, Washington, D. C. Present position: Assistant Superintendent of Nursing, in charge of Pacific Coast Territory, Metropolitan Life Insurance Company, San Francisco.

Bolton, Mrs. Chester C.

Honorary Trustee, Cleveland Visiting Nurse Association, Cleveland, Ohio.

Bowling, Gertrude H.

Graduate, Johns Hopkins Hospital, Baltimore; B.S., Teachers College, Columbia University. Positions held: Head Nurse, Johns Hopkins Hospital; A.E.F., Base Hospital No. 18 in France; Special Lecturer on Chautauqua Program, American Red Cross; Assistant Director, Visiting Nurse Association, Bridgeport, Connecticut. Present position: Director, Instructive Visiting Nurse Society, Washington, D. C.

Boyd, Ann Dickie.

Graduate, University of Colorado, Boulder; Newton Hospital Training School, Newton, Mass. Positions held: Follow-up Service, U. S. Veterans' Bureau. Present position: Supervisor of Nurses, Denver Public Schools, Denver, Colo.

Brock, Mrs. Elizabeth W.

President, Fourth District Texas Federation of Women's Clubs; Chairman, Health Committee, Brazos County Public Health Nursing Service; State Chairman of Arrangements Committee, for Lay Member Section, Convention of the three National Nursing Organizations, 1932, San Antonio, Texas.

Clapp, Raymond

Graduate, Chicago School of Civics and Philanthropy. Positions held: Member Finance Committee, N.O.P.H.N.; Chairman, Advisory Committee on Registration of Social Statistics, United States Children's Bureau. Present position: Director, Welfare Federation, Cleveland, Ohio.

Davis, Michael, Ph.D.

Director for Medical Services, Julius Rosenwald Fund, Chicago, Illinois.

Dunbar, Mrs. Saidie Orr

Executive Secretary, Oregon Tuberculosis Ass'n, Portland; State Chairman of Institutes, Oregon Federation of Women's Clubs; Member Executive Committee, General Federation of Women's Clubs.

French, Mrs. G. Decker

Name withdrawn from nomination after this page was set in type.

Hartley, Helen S.

B.S., University of Oregon; Graduate, Women's Hospital of Chicago; Public Health Nursing preparation, Teachers College, Columbia University. Positions held: Iowa Tuberculosis Ass'n, organizing and supervising public health nursing; Oregon State Advisory Nurse; Assistant Professor of Applied Sociology and Director of Public Health Nursing Course, University of Oregon. Present position: Superintendent of Public Health Nurses, San Joaquin Local Health District, Stockton, California.

Havey, I. Malinde

Graduate, Illinois Training School for Nurses, Chicago. Positions held: Industrial Nursing, Western Electric Company, Chicago; Student, Teachers College, Columbia University; Visiting Nurse, Ann Arbor, Michigan; Overseas, A.E.F., Base Hospital No. 36, Assistant Chief Nurse; County Supervising Nurse, Washtenaw County, Michigan; Director of Nursing, Lake Division, American Red Cross; Director of Nursing, Washington Division, A.R.C.; Assistant National Director Public Health Nursing, A.R.C. Present position: National Director of Public Health Nursing, A.R.C., Washington, D. C.

Houlton, Ruth

Graduate, University of Minnesota; Ancker Hospital, St. Paul, Minn. Positions held: School Nurse, Minnesota Public Health Association; Nurse, Washington, D. C., Diet Kitchen Association; Special Red Cross Nurse, Overseas, Army Hospital, France; T.B. Commission, Italy; Field Nursing Representative, Central Division American Red Cross; Superintendent Public Health Nursing, Minnesota State Department of Health. Present position: Director, Minneapolis Visiting Nurse Association.

Howell, Marion G.

Graduate, Wooster College; Lakeside Hospital, Cleveland; Post-Graduate Public Health Nursing, Western Reserve University, M.S. Positions held: School Nurse, Fairmont, W. Va.; Field Instructor, University Nursing District, Cleveland; Assistant Director Course in Public Health Nursing, Western Reserve University. Present position: Professor of Public Health Nursing, Western Reserve University, and Director, University Nursing District, Cleveland.

MacDougall, Eva F.

Graduate, Bellevue Hospital School of Nursing, New York. Post-graduate, Teachers College, Columbia University and

Henry Street Visiting Nurse Service, New York; Director Red Cross Health Center, Bronxville, Tuckahoe and Crestwood, Westchester County, New York; Staff Nurse, Visiting Nurse Association, New Rochelle, N. Y.; Assistant Director, Division of Public Health Nursing, Indiana State Board of Health. Present position: Director, Division of Public Health Nursing, Indiana State Board of Health, Indianapolis.

McKinney, Mrs. Roessle

Former President, Albany Guild for Public Health Nursing; Director, New York State Organization for Public Health Nursing.

Nelson, Sophie C.

Graduate, Waltham Training School for Nurses, Waltham, Mass. Positions held: Infant Welfare Nurse, Board of Health, Cambridge, Mass.; Overseas, American Red Cross, Chief Nurse, Children's Bureau, Lyons Area; Superintendent, Public Health Nursing Association, Louisville, Kentucky; American Red Cross Field Supervisor for Nursing Service in Central Europe and the Balkans for Relief Program; Director of Nursing, Boston Health League; Superintendent, Visiting Nurse Association, St. Louis, Mo. Present position: Director, Visiting Nurse Service, John Hancock Mutual Life Insurance Company, Boston, Mass.

Place, Sara Barclay

Graduate, Illinois Training School, Chicago. Positions held: Organizing Nurse, Community Nursing Program, Kewanee, Illinois. Present position: Superintendent, Infant Welfare Society, Chicago.

Priedeman, Mrs. John G.

Former Superintendent, Minneapolis Visiting Nurse Association; Member of Board of Directors, Minneapolis Visiting Nurse Association, Minn.

Rand, Winifred

Graduate, Smith College; Children's Hospital, Boston, Mass; Post-Graduate Course, Simmons College. Positions held; Neighborhood Nurse, Lincoln House, Boston; Superintendent of Nurses, Baby Hygiene Association, Boston; Director, Baby Hygiene Association, Boston; Director, Division of Child Hygiene, Community Health Association, Boston. Present position: Merrill-Palmer School, Detroit; Co-author with Mary E. Sweeny, M.S., M.A., and E. Lee Vincent, Ph.D., of the book "Growth and Development of the Young Child," published by W. B. Saunders Company, 1930.

Sheahan, Marion W.

Graduate, St. Peter's Hospital, Albany, N. Y. Positions held: Child Welfare Nurse, Cohoes-Albany, N. Y.; Henry Street Visiting Nurse Service, New York; City Nurse, Bureau of Health, Albany, N. Y.; County Nurse (Tuberculosis), Niagara County, N. Y.; Supervising Nurse of Tuberculosis, State Department of Health, N. Y. Present position: Assistant Director Division of Public Health Nursing, State Department of Health, N. Y.

Stockton, Eleanor

Graduate, Children's Hospital, San Francisco, Calif.; B.A., University of California. Positions held: Supervisor, Foster Home Division, San Francisco Department of Public Health, Supervisor, Child Welfare Nursing, San Francisco Department of Public Health. Present position: Director, Field Nursing and Social Service, San Francisco Department of Public Health.

Van Kooy, Cornelia

Graduate, St. Joseph's Hospital, Milwaukee. Positions held: Child Welfare Nurse, Milwaukee Health Department; Demonstration Public Health Nurse, Supervising Nurse and Director of Nursing Service, Wisconsin Anti-Tuberculosis Association; Supervising Nurse, Wisconsin State Board of Health. Present position: Director, Bureau of Public Health Nursing, State Board of Health, Madison, Wisconsin.

Wales, Marguerite A.

Graduate, Vassar College; Presbyterian Hospital School of Nursing, New York City; Post-graduate, Teachers College, Columbia University. Positions held: Rural Public Health Nursing, New York State; Director, Hospital Social Service, Stanford University Hospital, San Francisco, California. Present position: General Director, Henry Street Visiting Nurse Service, New York City.

Walker, W. Frank, Dr.P.H.

Graduate, University of Michigan. Positions held: Deputy Commissioner of Health, Detroit, Michigan; Field Director, Committee on Administrative Practice, American Public Health Association. Present position: Director, Division of Health Studies, Commonwealth Fund, New York, N. Y.

Winslow, Mrs. C.-E. A.

President, New Haven Visiting Nurse Association, Connecticut; Executive Committee, Board Members' Organization of Connecticut Public Health Nursing Associations.

WHAT HAVE YOU CONTRIBUTED TO THE ENROLLMENT?

Since the appearance last month of the Roll of Honor, more than one hundred and fifty local organizations have reported that their public health nursing staffs are enrolled 100 per cent as individual members in the N.O.P.H.N. Coupled with this outstanding showing are more than fourteen hundred applications and pledges of membership which have been received since October. This response indicates clearly that public health nurses and interested laymen throughout the country realize the need for mutual helpfulness and understand the obvious benefit to the movement as a whole of a solid national membership.

From the results already obtained the National Membership Committee is indeed tempted to make predictions of unqualified success for the balance of the effort. The success of the enrollment is, however, still dependent upon the continued coöperation of those who are already working, and upon securing the assistance of our entire membership.

For a member to be of greatest assistance in enrolling others, there are five definite steps to be taken. None of them will interfere with the regular routine of her job.

First: Question associates to find out whether or not they are enrolled.

Second: If not enrolled, find out why.

Third: Point out through the use of the booklet "Carrying Forward a Nation-Wide Service"* the advantages of membership, and the tangible services of the N.O.P.H.N.

Fourth: Mention that organizations with 100 per cent staff membership receive the Certificate of Honor.

Fifth: Ask if you may send in her name to the N.O.P.H.N. as an applicant.

It is not necessary that names be sent on formal application blanks, although the N.O.P.H.N. has them available if desired; nor is it necessary to collect the dues in advance. Merely drop a post card with the name and address of the applicant. Be sure to sign your own name, however, in order that you will receive full credit for your efforts.

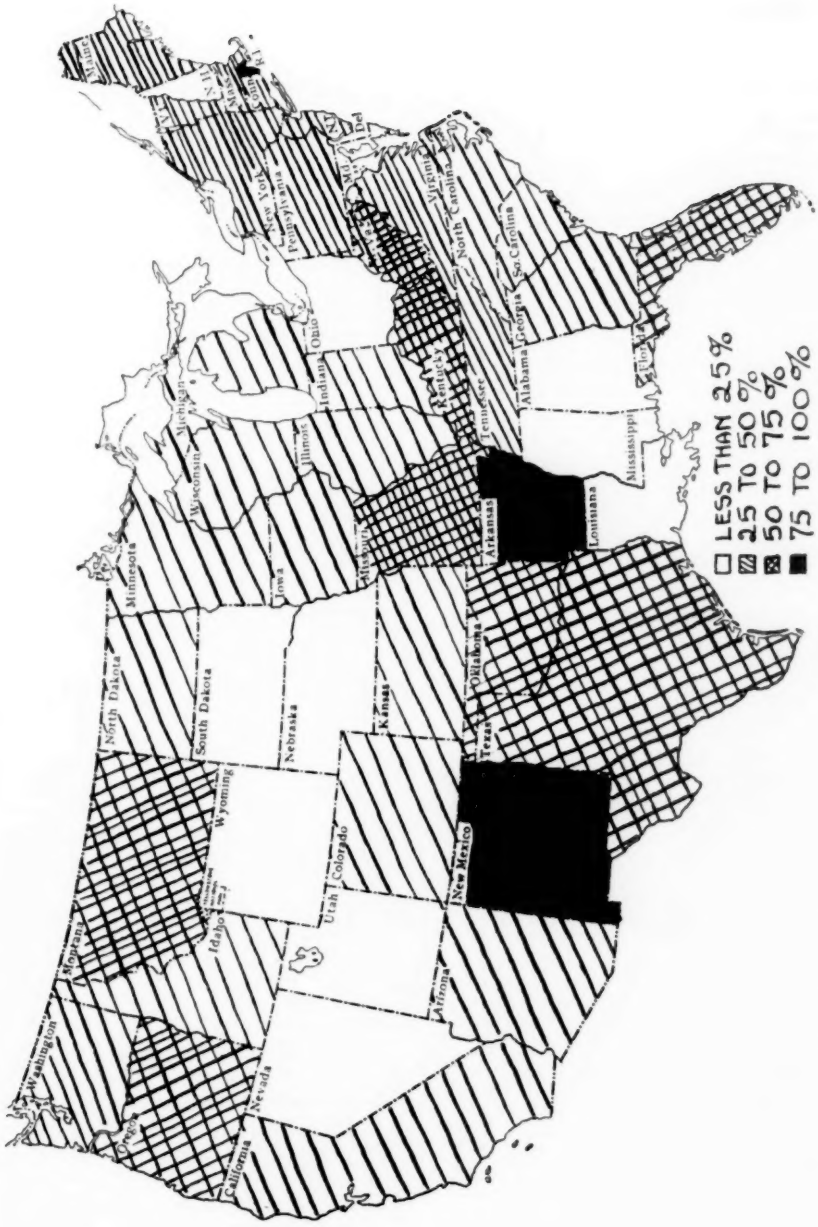
The first public health nursing association board to make N.O.P.H.N. sustaining membership a part of the regular dues paid by its members, is the Board of Directors of the Minneapolis Visiting Nurse Association. By the same unanimous vote it was also agreed to include membership in the Minnesota S.O.P.H.N. Each of the thirty-one board members will pay dues of five dollars a year, three dollars of which will be for membership in the National, one dollar for the state organization, and one dollar for the regular V.N.A. dues.

By this action the Minneapolis V.N.A. will be assured of permanent identification of its board with both state and national activities.

By assisting the N.O.P.H.N. to increase its membership you are helping it to maintain the services which it has fought so hard to establish. You are, in effect, helping it to serve you. So let us all work together that we may put the enrollment "over the top" by the time of the Biennial Convention in April.

*A new 20 page booklet, "Carrying Forward a Nation-Wide Service," which outlines the services which the N.O.P.H.N. offers to individuals, to agencies, and to the movement as a whole, has just been published by the N.O.P.H.N. Every public health nurse, health officer and layman interested in public health, should have one for reference. Copies may be had free from the N.O.P.H.N.

Doubled Membership Means Redoubled Strength



Map showing by states per cent of public health nurses who are N.O.P.H.N. members.

ROLL OF HONOR

(Continued from January—Nursing Staff Enrolled as Members of N.O.P.H.N.—100 per cent)

ALABAMA
Marshall County Health Department, Guntersville.

CALIFORNIA
Santa Barbara Visiting Nurse Association.

COLORADO
Weld County Chapter, American Red Cross, Greeley.
Visiting Nurse Association, Denver.

CONNECTICUT
Haddam Public Health Association.
Newton Visiting Nurse Association.
Public Schools of Stamford County.
Red Cross Nursing Service, Putnam.
Salisbury Public Health Nursing Association, Lakeville.

FLORIDA
Escambia County Public Health Nursing Service, Pensacola.

ILLINOIS
Chicago Tuberculosis Institute.
Joint Committee on Hourly Nursing, Chicago.
Moline Public Health Nursing Service.
School District, 131, Aurora.
Winnetka Relief and Aid Society.

INDIANA
County Public Health Nursing Service, Seymour.
Crawfordsville City Schools.
Delaware County Tuberculosis Association, Muncie.
Huntington Public Schools.
Public Health Nursing Association, Richmond.

IOWA
Lyon County Chapter, American Red Cross, Rock Rapids.
Monona County Chapter, American Red Cross, Onawa.

KANSAS
Geary County Health Service, Junction City.
Lyon County Health Unit, Emporia.
McPherson County Chapter, American Red Cross, McPherson.
Newton Public Health Nursing Association.

KENTUCKY
Fulton County Public Health Services, Fulton.
Public Health Center, Lexington.

LOUISIANA
Allen Parish Chapter, American Red Cross, Oakdale.

MAINE
Anti-Tuberculosis Association, Calais.
Augusta Chapter, American Red Cross.
Central Penobscot Public Health Association, Old Town.
District Nursing Association, Portland.
Livermore Falls Nursing Service.
Orono Community Nursing Service.
Penobscot County Nursing Service, Bangor.
Saco Red Cross Nursing Service.
Skowhegan Chapter, American Red Cross.

MARYLAND
Talbot County Health Department, Easton.

MASSACHUSETTS
Board of Health, Arlington.
Board of Education, Medford.
Newton District Nursing Association, Newtonville.
Visiting Nurse Association, Pittsfield.
Watertown District Nursing Association.

MICHIGAN
Hancock Public Schools.
Midland County Department of Health, Midland.
Visiting Nurse Association, Grand Rapids.

MINNESOTA
City Health Department, Virginia.

MISSISSIPPI
Union County Health Department, New Albany.

MISSOURI
Atchison County Health Service, Rockport.
Saline County Public Health Service, Marshall.

NEBRASKA
State Teachers College and Normal School, Kearney.

NEW HAMPSHIRE
Swanzey District Nurse Association, West Swanzey.

NEW JERSEY
Atlantic Highlands Public Health Association.
Cape May Branch, American Red Cross.
Matawan Public Health Association.
Red Bank Public Health Nursing Association.
Visiting Nurse Association, Plainfield.
Westfield District Nursing Association.

NEW YORK
Cayuga County Committee on Tuberculosis and Public Health, Auburn.
District Nursing Association of Northern Westchester County, Mount Kisco.
Dutchess County Health Association, Poughkeepsie.
East Aurora Branch, Buffalo Chapter, American Red Cross.
Eastchester Neighborhood Association, Tuckahoe.
Essex County Public Health Committee, Ticonderoga.
Genesee Visiting Nurse Association.
Glen Head School, Glen Head, L. I.
Hartsdale Public School No. 7.
Health Department and Board of Education, Chatham.
Joint Vocational Service, New York.
National Organization for Public Health Nursing, New York.
National Society for Prevention of Blindness, New York.
Neighborhood House, Tarrytown.
Onteora Branch, Greene County Chapter, American Red Cross, Tannersville.
Port Henry Health Department and Board of Education.
Township of Marlboro Nursing Service, Milton.
Town of Tonawanda Health Department, Kenmore.
Ulster County Committee on Tuberculosis and Public Health, Kingston.
Visiting Nurse Association, Syracuse.

NORTH DAKOTA
Cass County Public Health Organization, Fargo.
Health Department, Fargo.

OHIO
Hamilton Public Health League.
Henry County Board of Health, Napoleon.
Monroe County Board of Health, Woodsfield.
Norwalk City Board of Health.
Parma Board of Education.
Red Cross Public Health Nursing Service, East Liverpool.

OKLAHOMA
Tulsa County Public Health Association.

OREGON
Lane County Health Unit, Eugene.

PENNSYLVANIA
Bloomsburg Chapter, American Red Cross.
Fayette County Chapter, American Red Cross, Uniontown.
Fleetwood Visiting Nurse Association.
Franklin County Tuberculosis Society, Chambersburg.
Jeannette Branch, American Red Cross.
Northampton Branch, American Red Cross.
Palmerton School District.
Red Cross Public Health Nursing Service, Newton, Bucks County.
Slatington Public Schools.
Springfield Whitemarsh Visiting Nurse Association, Flourtown.
Tuberculosis League of Pittsburgh.
Visiting Nurse Association, Eastern Delaware County, Lansdowne.
Washington County Tuberculosis Association, Washington.

RHODE ISLAND
Providence District Nursing Association.
Woonsocket Public Health Nursing Association.

SOUTH CAROLINA
Anderson County Health Unit, Anderson.

TENNESSEE
Dyer County Health Department, Dyersburg.
Sevier County Health Unit, Sevierville.
Shelley County Tuberculosis Society, Memphis.

TEXAS
City Health Department, San Antonio.
County Public Health Nursing Association, Groesbeck.
Department of Public Health and Welfare, Fort Worth.
Department of School Health Work, Dallas Public Schools.
Houston Anti-Tuberculosis League.
Kerr County Public Health Nursing Service, Kerrville.
Red Cross Public Health Nursing Service, Galveston.
San Angelo and Tom Green County Health Association.

VERMONT
School Nursing Service, Johnson.
West Rutland Community Nursing Association.

VIRGINIA
Arlington County Health Department, Court House.
Charlotte County Chapter, American Red Cross.
Community Nursing Association, Salem.
Fauquier County Chapter, American Red Cross.
Instructive Visiting Nurse and Tuberculosis Association, Newport News.
Roanoke County Red Cross Nursing Service, Roanoke.
University Public Health Extension Service.

WEST VIRGINIA
Charleston Public Health Nursing Association.
Huntington Tuberculosis Association.
Marion County Health Unit, Fairmont.
Phillipi Public School.
Tucker County Health Association, Parsons.
Triadelphia School District, Wheeling.

WISCONSIN
Dane County Department of Public Health, Madison.
Grant County Nursing Service, Lancaster.
Marathon County Health Department, Wausau.
Walworth County Public Health Committee, Elkhorn.

NEWS FROM "J.V.S."

Unemployed-time is being turned into study-time by many nurses in touch with Joint Vocational Service. Nurses are finishing high school courses or supplementing their basic nursing equipment by taking graduate work in psychiatric nursing, communicable disease, tuberculosis, child health or obstetrics, according to their needs. Many are taking public health nursing courses.

At this time of fewer positions, Joint Vocational Service has been able to make a greater proportion of placements in public health nursing, partly because of the larger list of candidates from which to select, and partly because the Service has had a second vocational secretary in public health nursing this year, facilitating prompt service to both employer and candidates.

During November and December of 1931, 83 positions for public health nurses were filled by J.V.S., or through its assistance, as compared with 37 in the same period of 1927, 49 in 1928, 44 in 1929, and 49 in 1930. Of the 83 positions filled, nearly half were for emergency unemployment investigation where public health nurses were desired. The remainder were distributed in southern, midwest, and eastern states, in a variety of services, as follows:

Four nurses, to teach public health nursing and give supervision to students in the outpatient departments of three general and one maternity hospital; one, director of a large visiting nurse association; one, executive secretary-nurse of an American Red Cross Chapter; one, county nursing program; one, public health work with the Indians; twelve, field work on staffs of community nursing services in large cities, and seven, community nursing services in small towns; one, temporary statistical work in a national nursing organization; one, record nurse in a visiting nurse association; two, part-time resident nursing work in a settlement; one, assistant executive secretary of a state nurses' association; three, field and clinic work in social service departments of hospitals, both general and tuberculosis; a colored nurse, clinic and field work in a tuberculosis dispensary; one, staff nurse in a baby health center; one, school nurse in a small community.

BOARD AND COMMITTEE MEMBERS' FORUM

Edited by KATHARINE BIGGS MCKINNEY

AN UNUSUAL ANNUAL MEETING

From Miss Mildred Carlton, President of the Jackson County Public Health Association, Central Point, Oregon, comes this description of an annual meeting that was "different":

"Our meeting was the result of a revolt against the routine type of annual meeting which bored us all. We were tired of cut and dried reports.

"We asked each county chairman of the various committees to report on the year's work, *not by word of mouth.* Great was the tearing of hair as each committee struggled to think of new ways to dramatize its work!

"The chairman of the Finance Committee made placards showing increases in membership returns, community chest donations and other sources of income. The figures were large enough for every one to read.

"The Supply Committee had a clothesline which ran all across the room—the result amazing to all!

"The Publicity Committee had worked out short statements of what publicity means and what the public wants to read about.

"The Nurse's Committee selected a corner of the room and set up a model clinic, showing how to prepare the room for the nurse. We are trying to teach our clinic committees to have everything ready for the nurse when she comes, so that the impromptu preparation of the clinic was a good lesson for us all.

"Luncheon made a welcome break in the all-day session, and at luncheon the yearly financial statement was read for the benefit of the men present.

"In the afternoon, each community committee presented its most outstanding piece of work.

"A nutrition program dramatized safe milk and its value to the growing child. The children presented this in a little play.

"Health work in Medford was told by two youngsters dressed as their mothers, meeting on the street for a friendly chat.

"Moving pictures revealed the clinic and health activities in Central Point.

"A small rural district displayed a model hot school lunch.

"First aid and home nursing were demonstrated by another group.

"A monologue, cleverly acted, told of all the immunization work in another town, and a skit, presenting old and new fangled ideas on dental hygiene, served to show what was happening in Ashland.

"Everyone went home having had a day of fun with plenty of instruction thrown in. There were no routine reports, no motions, no formalities. We considered our plan a great success."

The Utica Visiting Nurse and Child Health Association held a one-day institute for board and members on October 16th, which was attended by 115 board members and nursing executives, including those from Utica and eight neighboring cities and towns.

Among the speakers were Mrs. C.-E. A. Winslow of New Haven, Mrs. Anne L. Hansen of Buffalo, Mrs. Jesse Bienenfeld and Miss Ellen Buell of Syracuse, and Mrs. William J. Baker of Rochester. An interesting feature was a Question Box at the close of the program which gave an opportunity for the discussion of questions and problems which had not received attention earlier in the day.

All expenses of the Institute were met by a registration fee of $1.00.

The full program offered to board members at the Biennial Convention will be published in this department in March. We call attention to the N.O.P.H.N. ballot for officers and directors for 1932–1934 (page 106).

The midmonthly *Survey* for December, 1931, contains a timely article on salaries by Mrs. C.-E. A. Winslow, which will interest our readers.

POLICIES AND PROBLEMS OF PUBLIC HEALTH NURSING

Among the following " devices " which have reached the N.O.P.H.N. in correspondence or have been " lifted " from current bulletins, are the following, among which you may find your own brain-child introduced to the world; something to help you in your specialty; something of interest in the generalized field.

GROUP TALKS TO CHILDREN

If I were to sum up the best method of getting ideas across from teacher [and nurse] to child, I would say :—

1. Never talk longer than twenty-five minutes.
2. Always put what you have to say in a simple way, and in the form of an interesting story, to be continued in the next talk.
3. Give the children one or two good laughs in each instalment.
4. Use the blackboard freely to illustrate the talk.
5. Divide the talks into at least six chapters.
6. Do not give more than one a week.
7. Always give a summary of the previous talk at the beginning of each.
8. Ask questions to enable you to judge if the children have grasped the vital points.
9. Put each point in several different ways in order to reach the mentality of each child.
10. Tell your story—don't read it.

The " facts of life " have to be told to the child in such a way that they will not be cold facts but living thoughts that may contribute to the building of character. I therefore determine that I will try to make them understand the meaning of love and faith, growth and effort, urge and attraction, also giving them some idea of the use of pain and the wonder of protection.

—*Social Hygiene in a Day School* by *A. R. Tunstall Haverfield* in *Health and Empire.*

REMOVING IODINE STAINS

Laura S. Pratt, R.N., of the National Blank Book Company, Holyoke, Mass., suggests that the immersion of wearing apparel or other fabrics in boiling water will remove quickly even old iodine stains.—*Industrial Health Digest.*

HOW LONG MUST DISHES BE BOILED TO BECOME STERILE?

That disease organisms may be transferred by contaminated dishes unless the dishes are boiled for at least fifteen minutes or steamed for at least twenty minutes, is the conclusion to be drawn from the results of a laboratory experiment of nursing methods and materials conducted in the department of nursing education, Teachers College, Columbia University.

Full tray sets of dishes—spoons, forks, cups and plates—were used in the experiment. These were inoculated with soft egg yolk containing fresh cultures of bacteria—coli and staphylococcus. These dishes were allowed to dry for ten minutes and were then boiled or steamed for periods varying from five to twenty minutes. The survival of the test organisms was shown by swabbing

the dishes and incubating the swabs in appropriate kinds of broth—dextrose broth for staphylococcus and lactose broth for coli organisms.

On 144 coli dishes, no organism survived boiling periods of five or more minutes, although coli organisms persisted on two of the eight dishes that were steamed but five minutes. Of 140 staphylococcus dishes, the organism persisted on half of the ninety dishes that were boiled five to ten minutes, or steamed five to fifteen minutes, but did not survive on the remainder of the dishes used in the experiment.—*The Modern Hospital.*

STERILIZING TUBING USED FOR ENEMAS AND IRRIGATIONS

Apparently any method of washing rubber tubing used for enemas and irrigations may be used provided it is followed by boiling for three minutes, according to the results of an experiment conducted in the department of nursing education, Teachers College, Columbia University, and reported in the *Nursing Education Bulletin.* The experiment further proved that the boiling may be reduced to two minutes, if "forced flush" cleansing is used, but that the simplest method is washing the tubing at the tap until the water runs clean and then boiling it for three minutes.

The method of procedure in making the experiment was as follows: One hundred and fifty short pieces of tubing were contaminated with staphylococcus and coli, allowed to dry for ten minutes and then washed or flushed in various ways—with soap, without soap, and by using a "forced flush" which was secured by attaching a small diameter nozzle to the faucet. After washing, the tubing was boiled, the time varying from one to ten minutes. The results were tested by taking swabs or samples from the insides of the rubber tubes and by soaking the tubes in sterile broth and using samples of the broth. The test samples were inoculated in dextrose broth to see if staphylococcus organisms survived and into lactose neutral red broth to see if the coli organisms were still alive.—*The Modern Hospital.*

DO YOUR PUPILS BUY WELL-BALANCED LUNCHEONS?

Luncheons which pupils buy from the school lunchrooms are being checked in certain schools, and the children who have selected a well-balanced lunch are given "A" cards. Tickets explaining the deficiencies are given to those whose lunches are not well-balanced. This method has resulted in a marked increase in the consumption of milk, and in the interest shown by the mothers. This scheme for making the school lunch an integral part of the health curriculum is being worked out for the National Dairy Council, by Dr. Lydia J. Roberts, of the University of Chicago. When the study is completed, the plan and lessons will be available for schools throughout the country.—*Child Welfare.*

The Bergen County Tuberculosis and Health Association, Hackensack, N. J., writes of a well-run school lunch project in Demarest, N. J. The lunchroom is a project of the Parent Teachers' Association. Each morning two mothers come to the school, prepare a wholesome lunch and serve it to the children for a "mere song" (about 12¢). This is an admirable plan for a small school. The lunch room itself is most attractive with its walls painted yellow, cheerful drapes at the window, attractive tables and chairs—small ones to fit the younger children, and middle sized ones to fit older boys and girls.

HOW ONE GROUP OF EMPLOYEES ESCAPED BOILS

Winifred Hardiman, R.N., of the Terry Steam Turbine Company, Hartford, Conn., writes to the Cleanliness Institute that boils are now conspicuous by their absence among the company's employees:

This is not because we have changed our cutting oils or any other system in our plant, but, we believe, because we worked on the basic principle of cleanliness.

We know nothing about boils, except that, according to Hoyle, we must call them furuncles, and that presumably the cause was our cutting oils. I was introduced to them in 1918, innumerable cases of them. On, on they came. Finally they became personal. This was too much—I was *forced* to think about them! How did I get boils? I never touched oils or machinery other than the human machine. That being so, my technique must be bad, and carelessness in washing up must account for my infection.

Then I noticed that each time a "boiler" reported from a certain department others would follow; in fact, it seemed a regular epidemic. It was "okay" with them—they *expected* to have about nine, according to the common tradition. Sarsaparilla, sulphur and molasses internally, and applications of tobacco, salt pork, sugar, and soap were considered the sure cure. The moderns took yeast cakes. They revelled in the thought that their bad blood was coming out this way.

These boils were one of our great annoyances. The doctors blamed cutting oils; but some "boilers" did not use oils. Upon investigation we found that the majority of employees handled blue prints. These were passed from man to man; likewise, other material passed through. This indicated direct contact as the agent. I began to talk personally to each "boiler" about the efficacy of cleanliness. But the boils still continued, though in a less degree. Finally, to give a picture of what I meant by cleanliness, I began to demonstrate. Pictures in the book of physiology and hygiene showing pores and follicles created a live interest.

"Watch me." I rolled up my sleeves. "Get a scrubbing brush from the 'Five and Ten,' use plenty of warm water, and a good soap."

I scrubbed and scrubbed with a hand-brush, arms, hands, and fingernails, explaining the great necessity for cleanliness, particularly when boils run amuck. I told them that the tiny "bug" buried itself under the skin around the hair follicles, which caused the trouble; that the "bug" was of the pus-producing variety—it did not float in the air, but spread by contact—hand contact. Therefore, the hands must be scrubbed often and thoroughly. The only preventive treatment was to eat right and keep clean.

School nurses and all those who use blackboards will be interested in a new chalk which marks in clear white lines, or yellow if desired—yellow chalk is the latest recommendation of the National Society for the Prevention of Blindness—and is larger in circumference than ordinary chalk and therefore more comfortable to hold. Have you had difficulty with the visibility of uneven lines of chalk letters or have your fingers been cramped at the end of writing questions on the board? Here is your remedy!

—Textile Mill Chalk, The American Crayon Co., Sandusky, Ohio.

ACTIVITY RECORD

This activity record is in use in the East Harlem Nursing and Health Service, New York City, and has been filled out from a supervisor's actual record. Miss Grace L. Anderson, director of the Service, writes: We feel that before the supervisor makes a visit, she should talk over with the nurse the visit to be made; read the record and discuss any points not clear. This plan makes the supervisor's visit more helpful in every way.

The supervisor uses this complete record of items as a guide and selects those items especially applicable to her visit. Some points may not be demonstrated during the visits, others may be so well known as to be unnecessary to record each time—*e.g.*, "Dresses on duty."

Name

Date

Cases Observed

1. N.H.
2. N.H.
3. A.P.—para 1, 8 mos.
4. A.P.—para 2, 5 mos.
5. P.P.—N.H.

1. *Plans Work*

Miss Jay is carrying her own district as well as certain calls in Dist. III. Both districts are large and carry a large number of A.P. mothers. It was apparent from the first that Miss Jay was handling this load well through careful planning. In homes where the mothers are frequently out she leaves messages or notes asking the mother to stay in on a certain half day for a nursing visit. In this way she saves time and steps. She has a definite purpose in going to each home.

2. *Approach*

Both families were new to Miss Jay, although they had been visited by other nurses. She always introduced her visitor and herself. Her manner is friendly, calm, matter-of-fact and well poised. She concentrates on her work and comes to the point with little waste of time or words. The mothers seem to place their confidence in her immediately and bring their difficulties to her. Her whole manner expresses a genuine interest in people.

3. *Gives Nursing Care*

In the two ante-partum homes; complete nursing care was given: urinalysis, blood pressure, temperature and inquiry into general physical condition. Technique carefully and neatly carried out. Certain changes in procedure will make technique more routine and save time, such as: boil brush and test tubes separately, use small basin for extra water and prepare cotton pledgets for cleaning urinometer before starting procedure.

4. *Sees Important Factors in a Situation*

In Case 3, Miss Jay was concerned with the physical condition of the ante-partum mother who was nearly due. She inquired into the mother's and father's desire for a boy or girl and through this found out something of the mother's and father's attitudes and care for each other and desire for baby.

In Case 4 the physical condition was again important but Miss Jay realized that gaining the mother's real interest was necessary before doing much constructive work in the home.

5. *Teaches*

Miss Jay listens well and with genuine interest to what the families have to tell. Her advice or suggestions are always simple, clear and concrete. Instructions were based on actual situations and were extremely practical. She explained in Case 3 the causes of albumen and suggested a diet. With further experience she will use her technique more as a teaching device. More skill in asking questions and making comments will bring integration and smoothness in her teaching. She uses praise as a definite tool in her contacts.

6. *Records*

Records are complete and accurate. Content is well chosen. Social data are well recorded.

7. *Follows Up Cases*

Both families were new to Miss Jay and her follow-up work showed that she was familiar with the record. In Case 3, she inquired about Berwind Clinic attendance, progress with supplies and other preparations for delivery. In Case 4, she followed up plans for registration. In Case 5, she inquired about relative's condition and reason for the newborn's death.

8. *Resources Used*

Berwind Clinic—Case 3.
Lying-In Hospital—Case 5.
Midwife—Case 4.
Miss Jay is familiar with agencies and uses resources easily.

9. *Looks for and Works on Problems*

Miss Jay gets as much information as possible about particular families or individuals in an effort to determine further problems to be worked on. She is not only conscious of new situations in her "carried families" but is also aware of problems in "not carried families" wherever she may meet them and is practical in the advice she gives to them. She decides to carry the family if necessary. In this way she has found a number of new ante-partum cases.

10. *Studies to Improve Methods of Procedure*

Miss Jay finds that this work differs very much from what she is accustomed to. She has familiarized herself with agencies and the handling of records. She is now working on increasing her subject matter and gaining greater skill in teaching.

11. *Dresses on Duty*

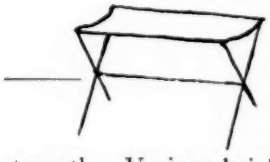
Full uniform is always worn.

12. *Conference with Worker—Date*

Miss Jay was interested in comments on her visits and discussed her difficulties frankly. It was suggested that she analyze her successes critically in order to become more conscious of her methods. Continued practice in the field will make her a splendid public health nurse.

Supervisor

INFANT'S FOLDING DRESSING TABLE



This device is in use in the child health conferences of the St. Paul Baby Welfare Association, St. Paul, Minnesota. The frame is 22 by 30 inches, and the legs are 32 to 42 inches. The frame is wooden, covered by white washable duck applied with thumb tacks. The cross piece adds strength. Various heights of tables are in use in each conference. They can be folded and put away between conferences.

Washable paper gowns, for use in communicable disease service, can be obtained from the Allor Surgical Specialty Company, 9205 Woodhall Avenue, Detroit, Michigan. The gowns fasten down the back. Cost .35 in quantity orders.

REVIEWS AND BOOK NOTES

Edited by RUTH GILBERT

RELIEF WORK IN THE DROUGHT 1930–31

An Official Report of the American National Red Cross, August, 1930, to June, 1931. Published by the American Red Cross, Washington, D. C.

The report sets forth in a concise and interesting style outstanding facts concerning the nature of the drought which made it a national emergency, and the organization for relief called together under the auspices of the Red Cross. The drought of 1930–31 was outstanding in the experiences of the country in the last fifty years, covering a longer period, being more widespread and accompanied by a general economic depression. Its effects were felt by nearly 3,000,000 persons in twenty-three states. The deficiency of rainfall was as much as fifty per cent in five of these states.

The program can be roughly divided into two parts—relief work and rehabilitation. Approximately eighty per cent of the total expenditure went into the relief activities. The details of the program are readily visualized from the financial statement given in the Report: $7,229,000 expended for food; $488,000 for clothing; $165,000 for school lunches; $346,000 for feed for live stock; $768,000 for garden and pasturage seeds; $216,000 for health and medical aid and nutrition service for families; $835,000 for field supervision and accounting; $719,000 in grants to chapters; and $115,000 for other miscellaneous supplies.

The funds were derived from direct contributions for drought relief and from the reserve fund of the American Red Cross. The personnel was to a considerable degree that of the local chapters with the national organization supplying such advisory and supervisory services as were necessary. Nearly $11,000,000 was spent through these channels. In addition, $2,000,000 was provided by the federal government for public health services through the United States Public Health Service and over $60,000,000 was provided by the federal government from loan funds.

Ample evidence of the effective administration of the relief program is given. The results of rehabilitation work though apparent in measure this year, may be even more evident in greater individual preparedness and better community organization in the future.

W. F. WALKER.

ALLERGY

By Warren T. Vaughan, M.D. C. V. Mosby Co., St. Louis, Mo. $4.50.

The study of allergy has aroused the interest alike of physicians and laymen during recent years. It is with difficulty and some surprise, however, that those unfamiliar with professional terminology have recognized under this title their old enemies, asthma, hay fever, eczema, and kindred manifestations.

Dr. Vaughan's book contains the necessary information on these subjects for nurses, medical students, graduates in medicine, and those specializing in medicine in allergy. It is to be recommended strongly for nurses because of its clear delineation of symptoms, prognosis, and treatment, and meets the demand of this profession better than any other book published on the subject at this time.

ROBERT E. JAMESON.

BREAST-FEEDING

By Margaret Emslie. Oxford University Press, New York. $2.00.

To those of us who are interested in obstetrics and pediatrics—in fact, in nursing—the reading of Margaret Emslie's book, "Breast-Feeding," will be time well spent. Recently so much space has been devoted to foods and formulae for the baby, that our attention may have been a bit diverted from

this subject of breast-feeding. Miss Emslie reminds us of the fact that, as nurses, we have a duty towards babies and mothers in our teaching opportunities, and presents the subject in such a manner that a mother may well consider the nursing of her baby "a privileged service of unequalled value" to him.

Miss Emslie recognizes the fact that there are instances where breast feeding is contra-indicated as in the case of organic disease, but thinks we should not be as easily diverted from this feeding method as we seem to have been in many instances. The doctor's training may have shown him more of artificial feedings than of the details of breast-feeding technique; the field for commercial exploitation is large and ingeniously presented. Therefore the nurse finds instruction of mothers in the importance and method of breast-feeding, a field of usefulness peculiarly her own.

Perhaps if this subject is to be appreciated, it must be taken from the several text books and presented as a subject by itself, as this volume has attempted to do.

LOUISE ZABRISKIE

SPEECH PATHOLOGY

By Lee Edward Travis. D. Appleton & Co., New York. $4.00.

I agree fully with the publisher's statement that "The book is thoroughly scientific in its discussion of causes and treatment. It is an indispensable manual for psychologists, physicians, teachers, social workers, speech and voice experts, and everyone who has to do with either child or adult speech defects."

The discussion is at times perhaps over-technical for the average teacher or nurse, but of interest to them, nevertheless.

While I do not agree entirely with Travis's theory of the cause of stuttering, this is of minor importance. The general excellence of the book and the success of Travis's clinical work make the book the best on the subject that has yet appeared.

FREDERICK W. BROWN

CLEVER COUNTRY

By Caroline Gardner. Fleming H. Revell Company, New York and Chicago. $1.50.

"Clever, it should be explained," says Mrs. Gardner, Executive Secretary in Chicago of the Frontier Nursing Service, "is mountaineer for generous, just as common means friendly, and pretty, healthy."—And just as "Frontier Nursing Service" means able nursing service primed with vigor and sensitivity, in the language of mountaineer and urban dweller alike, we might add.

Mrs. Gardner and her children visited the Frontier Nursing Service during summer months with this description of the work of nurses, aides, administrators and mountain people as a result. The story element is very slight and serves only as a continuity for sympathetic tales of and by the nurses as they carry on their family work in this rugged mountain country. No detailed description of the Service is attempted. Rather Mrs. Gardner has given us a series of pen sketches which pique our imagination and gain our interest. The book is pleasantly informal, and has real humor in its description of attempts to ride strange horses over hair-raising trails, and efforts to adapt to inconvenient living arrangements.

R. G.

A list of books that permit people to read with the least amount of fatigue has been compiled by Charlotte Matson and published by the American Library Association, 520 North Michigan Avenue, Chicago, under the title *Books for Tired Eyes*. Price 50c. This list is especially desirable for people with defective eyesight and even people with normal vision will find relaxation in the books recommended. The books have been chosen with due regard for the differing tastes of readers.

A list of books in extra large type, the "Clear Type Series," calls attention to books which may be enjoyed by even those whose eyesight is unusually poor.

Public Health Nursing Service in Rural Families, by Marion G. Randall, reprinted from the Quarterly bulletin of the Milbank Memorial Fund, v. IV, No. 4, October, 1931, is a study from nursing records of how completely a public health nurse may discharge her responsibilities in a rural county. Cattaraugus County, N. Y., offered an opportunity to study rural families, their health problems and the amount of nursing service received over a given period. The inquiry "ascertained the amount and kind of public health nursing supervision received during a twelve-month period by an *unselected* group of families of varying size and age composition and economic status."

The leaflet will be found helpful and well worth study by those carrying generalized rural services. It gives useful pointers in selecting families in which service can best be rendered.

The Organization and Administration of Public Relief Agencies has just been issued by the Family Welfare Society of America, 130 East 22d Street, New York City. This handbook, prepared at the request of the President's organization on unemployment relief, is intended as a practical guide for all who are interested in organizing or making more effective public welfare agencies administering relief. A limited number of copies are available for free distribution; additional single copies, 35c.

Personnel and Health Work is Pamphlet No. 15 of the Health Practices series, published by the National Safety Council, Inc., Chicago. Industrial nurses will find this material of practical help. The six pages of the pamphlet deal in brief form with the following among other topics: Physical and mental health and personnel relations; professional people as personnel workers; management's responsibility; production and health; cafeterias and lunchrooms; rehabilitation; group conferences.

Public health nurses engaged in industrial work will be interested in *Hidden Costs in Industry* published by the American Social Hygiene Association, 450 Seventh Avenue, New York City. Syphilis and gonorrhea as a serious health hazard in industry are approached through the practical questions: Nature of these diseases; frequency; cost to industry and its workers; what can be done; suggestions for employers. Price 10c; $7.00 for a hundred copies.

The Department of Health, New York City, has published through its Committee on Neighborhood Health Development, the second edition of *Health Center Districts*. This handbook is local in its specific information but because of its contribution to city-planning, with health as a fundamental consideration, and because of its outline of the part to be played by both public and private agencies, has practical value for public health workers, physicians, and social workers.

The information contained includes: District population; schools; local reports of births, infant and general mortality; tuberculosis and infectious disease registration; public health nursing requirements.

The attractive and practical format of the handbook deserves imitation for its cleverly inexpensive binding and its excellence in the reproduction of maps and statistical material.

A set of *Prone Pressure Posters* illustrating this method of artificial respiration is now available from the National Safety Council, Inc., 20 North Wacker Drive, Chicago. The set consists of five charts, approximately one by two feet, price for one set, 20c.

Canned Food Recipes for Cafeterias and Restaurants, Bulletin No. 110-A, of the National Canners Association, Washington, D. C.; may seem a bit far afield to many nurses, but to those who are helping to organize hot

lunches on a large scale in school and industry, the material will be invaluable. Available on request from the Home Economics Division of the Association.

FROM CURRENT PERIODICALS

Are we becoming overly health conscious? John Sundwall, Journal of health and physical education, October. Far from being overly health conscious, we are just beginning to realize the dawn of health consciousness.

The boy in home economics. Helen Redford in Child welfare for December.

Child labor yesterday and today. Courtenay Dinwiddie in the American child for December.

Community organization for diphtheria prevention. Esther Nash in Public health, Michigan department of health, September. Helpful suggestions on preliminary planning, financing, organization and publicity.

Control of gonorrhea. Taliaferro Clark in Venereal disease information for September 20.

Costs of medical care and health services. William DeKleine in Red cross courier for December.

Further experience with B.C.G. vaccine. A. C. Rankin in Canadian public health journal for September.

The future of the nurse is the responsibility of today. C.-E. A. Winslow in Modern hospital for December. A discussion of some of the trends revealed by the Committee on grading of nursing schools.

How public health nursing can best serve the community. Sophie C. Nelson in Modern hospital for September.

Human side of the hospital. Joseph Brennemann, in Journal of American medical association for November 14.

Institutional care for the crippled adolescent boy and girl. Frances E. Shirley. *Adult sex hygiene and family case work* by Harry L. Lurie in collaboration with Minnie J. Rosenthal and Eva M. Weber. Both in Hospital social service for November.

Is it trained worker vs. board member? L. L. Strauss in Survey for December 15.

Mouth health a part of a public health program. John J. Sippy. Mouth health quarterly, October. This Quarterly to be published monthly by American mouth health association, Minneapolis.

Need for education in questions of sex. T. W. Pym in British medical journal for August.

The nurse and the health officer. Agnes Martin in American journal of public health and the nation's health for November.

A nurse writes in from the wheat belt. Aagot Lian in Survey, October 15.

One hundred cases of early weaning, a summary of a study by H. W. Pooles. Maternity and child welfare (London) for November. Analysis of 100 cases of breast feeding to end of first month.

The other four-fifths. Thurman R. Rice in Monthly bulletin, Indiana state board of health for October. Making the masculine element of the community take a larger part in the health program.

Outlines for teaching oral hygiene from the kindergarten to the eighth grade. Emma P. Durbin. Journal of American dental association for December.

Parent training. R. R. Struthers in Canadian nurse for November.

The pleasures and perils of bathing, Henrietta MacFarland; and *Some famous milk addicts,* by James A. Tobey in Hygeia for October. In Hygeia for November, *Cold facts about colds* by R. R. Spencer; *Epilepsy and epilepsy nostrums,* editorial; *Some common causes of earache,* by Joseph Popper. For December, *Choosing the right toys* by Ruth L. Frankel, an article on teaching world peace to children; *Fifty ways to use the hourly nurse* by Miriam Ames. In Hygeia for January, 1932, *Keeping the convalescent child happy* by Louise Price Bell.

A positive Wassermann, by a victim. Survey, October. Some of the complications that may result when medical science fails to humanize its clinics.

Present status of the control of poliomyelitis. S. D. Kramer in Medical times and Long Island medical journal for December.

Syphilis—Some psychologic aspects of treatment. Gerald H. J. Pearson in Archives of dermatology and syphilology, June, 1931.

Responsibility of the nurse for the instruction of patients in the out-patient department. Catharine Weiser. American journal of nursing, October.

A study of habit clinic children having convulsions. Bulletin of the Massachusetts department of mental diseases, October, 1930.

Viasterol and cod liver oil. E. O. Prather, Jr., Martha Nelson and A. Richard Bliss, Jr., in American journal of diseases of children, July, 1931. "Since colds, malnutrition and intestinal inadequacies are more frequent in children than rickets, this study emphatically suggests that the apparently widespread substitution of viasterol for cod liver oil is not logical and may result in decrease of the child's . . . resistance to infections."

What grown-ups cry for. Stanley P. Davies in Survey for December 1. Has an eager public been oversold on mental hygiene?

What should a juvenile courtroom look like? C. A. Gates in Probation published by National probation association for December.

When our death-rate goes up. Henry Pratt Fairchild in graphic survey, September 1, 1931.

NEWS NOTES

The 200th anniversary of the birth of George Washington will be celebrated during 1932 with appropriate ceremonies in Washington, D. C., and in the states. To participate in various features of the celebration, many associations have decided to hold their annual conventions in Washington next year. The American Public Health Association, oldest and strongest organization of its kind on the continent, is one of those. Its Sixty-first Annual Meeting will be held in Washington from October 24 to October 27. The Willard Hotel will be headquarters.

✤

While some states are supporting the maternity and infancy program formerly carried by the Sheppard-Towner funds, others have allowed this work to lapse, according to an investigation made last summer by the National League of Women Voters. A recent article appearing in *The Survey* states: "Approximate figures . . . reveal that in 1932 only twenty-one states will carry on a maternity and infancy program approximately equal to or slightly exceeding the program they conducted under the Sheppard-Towner act; nine states will carry on a program apparently equal to one-half or more of the program of 1928; twelve states and Hawaii will do less than half; three states have no appropriation available. . . ."

✤

The Eighth Conference of the International Union Against Tuberculosis will be held at The Hague and Amsterdam from September 7–9, 1932, under the chairmanship of Professor Nolen.

The following subjects have been selected for discussion:

Relationship between Allergy and Immunity
Gold-Therapy
After-Care Schemes for the Tuberculous

The reports submitted by ten speakers selected from a long list of candidates will be followed by a free discussion open to all members of the International Union, as well as to "Members of the Conference" officially nominated by National Associations affiliated with the Union.

According to a custom which has become established, the Netherlands Association against Tuberculosis will organize a study trip for the members of the Conference.

✤

The second International Conference on Social Work will be held in Frankfort-am-Main, Germany, July 10–July 15, 1932. The general theme will be "Social Work and the Family."

✤

A preliminary conference on National Negro Health Week for 1932 was held in Washington, D. C., in November. The meeting was opened by the presiding officer, Dr. R. C. Williams, followed by a few words of greeting from Dr. Tolliver Clark, the Acting Surgeon General.

A year ago a committee of five was appointed to discuss the purpose, program and policies of Negro Health Week. This committee recommended that the name of the organization be changed to the National Negro Health Movement with an all year round program, and the employment of a full-time field secretary. The following program was recommended for the 1932 observance of National Negro Health Week:

Continuance of the prescribed Health Week program, with emphasis on practical health measures, such as clinics, clean-up activities, and efforts to secure permanent health improvements and full-time colored health workers; pictorial number of the Health Week bulletin; preliminary Health Week announcement to be issued by the U. S. Public Health Service; Health Week poster with subject, text, and color composition as in former years, the selection to be made by a Poster Contest in the colored schools, details to be stated in the preliminary Health Week announcement; objective for the year 1932: "Help Yourself and Your Community to Better Health."

The time set for the 1932 Negro Health Week is April 3d to 10th, but the plans are to carry on an all year round program with an intensified program during this particular week.

✤

Modern Hospital describes the Joseph Samuels' dental clinic for children at the Rhode Island Hospital, Providence, as "the first modern clinic of its kind to be made a part of a large general hospital." This clinic occupies a distinctive position in that opportunity is afforded for direct coöperation between the dental and the medical staffs."

✤

A recreation worker now is a part of the staff for the weekly pediatric clinic held by the Tarrytown (N. Y.) Nursing Service. This worker provides worthwhile occupation for the toddlers who accompany mothers and infants to the clinics.

A committee of physicians appointed by Dr. Shirley W. Wynne, health officer of New York City, is to prepare plans for a city-wide program looking toward the control of tuberculosis in children.

✚

In July, 1932, at Honolulu, Hawaii, will occur the Regional Conference of the World Federation of Education Associations. The conference will relate to all countries in the Pacific and will deal with such subjects as the Dual Language Problem, Modern Educational Problems in the Oriental Setting, Vocational Education, Health Education and Adult Education.

For information concerning the program, write to the President, Dr. Paul Monroe, 525 West 120th Street, New York City.

For matters pertaining to travel, accommodations and general arrangements, write to the Secretary-General, 1201 Sixteenth Street, Washington, D. C.

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The town of Orange (Conn.) has voted a sum of $1,000 to be used for generalized public health nursing. The service will start on a half-time basis and will be supplied by the Ansonia, Derby, and Shelton Public Health Nursing Association as a further development of the present specialized service to schools. Orange will receive a subsidy from the state.

✚

Dr. Earl D. Bond of Philadelphia in a discussion of mental diseases, their treatment and prevention, gave psychoanalysis credit for much of the progress made in understanding these conditions in recent years. He said that, among other things, it taught physicians to "listen to their patients" and, by becoming better listeners, how to increase their effectiveness as therapists.

✚

The medical school of the University of Illinois has instituted a comprehensive series of experiments in the growth of hair on the human body, particularly the scalp. Dr. B. N. Bengston of Maywood, Illinois, has been taken on the staff and has organized an experimental class at the Research and Educational Hospital in Chicago. Out of one hundred applicants, fifty have been accepted and will receive hypodermic injections of a pituitary extract which is the discovery of Dr. Bengston. The Journal of the American Medical Association has published an article describing Dr. Bengston's methods.

✚

With the building of a new motor road across the Swiss Alps, passable in summer as well as winter, the monks of St. Bernard find the rescue work which they and their famous dogs have carried on for almost a thousand years, no longer needed. A chapter of this Order plans to establish new headquarters on one of the most frequented and difficult passes of the Himalaya Mountains to carry on their work of protecting travelers in distress.

✚

The Annual Dinner of the District of Columbia League of Nursing Education was held Thursday, December 17, 1931, at the American Association of University Women, Washington, D. C.

Dr. Earl Baldwin McKinley, Dean of the George Washington School of Medicine, spoke on: "Nursing Education from a University Viewpoint."

✚

Mrs. Winifred Hathaway, associate director of the National Society for the Prevention of Blindness, is spending six weeks in Hawaii where she is lecturing at the University of Hawaii and giving demonstrations of eye tests for preschool children.

✚

Mrs. Marion Turner Brockway, who has been "house mother" of the Metropolitan Life Insurance Company for twelve years, retired on January 1. Frederick H. Ecker, president of the company, presented Mrs. Brockway with a platinum wrist watch on behalf of the employees. He spoke briefly, complimenting Mrs. Brockway on her success in her relations with the employees and wishing her enjoyment from the years of leisure to which she is looking forward. Mrs. Brockway sailed on January 22 for Italy.

✚

A school examination paper in history included the following question, "What was Old Ironsides?" Having been impressed recently by an account of the work of Florence Nightingale, small Tony felt sure he was correct in the following answer, "Old Ironsides was a Red Cross nurse."

—From a monthly report published by the Red Cross Courier

APPOINTMENTS

Katherine Stenger as a school nurse at North Platte, Nebraska.

Esther Ericson as a staff nurse with the Portland (Oregon) Visiting Nurse Association.

Shirley Vergeer and Marie Dyer as staff nurses with the school division of the Portland (Oregon) Health Bureau.

Mrs. Glendora M. Blakely has resigned from the State Bureau of Public Health Nursing, Oregon, with a record of ten years' service. Her position is filled temporarily by Mrs. Minnette C. Twist, state field nurse.

Marion Douglas as director on April 1, of the Visiting Nurse Association, Hartford, Connecticut.